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MENTAL HYGIENE

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THE BEHAVIORISTIC ATTITUDE*

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I HAVE been asked to approach the problem of community work from the standpoint of behaviorism, as it is called, and to outline such of the fundamental assumptions of modern psychology as may be of practical service to the community worker, enabling such worker to function more intelligently. In order that I may do this, I must first outline what I conceive to be the behavioristic attitude.

Behaviorism looks upon what a man does in contrast to what he thinks and feels—that is, upon his conduct—as being the most important expression of his psychology. In other words, his actions are taken as the only authoritative expression of what he is. Thinking and feeling have significance only so far as they are preparatory for and lead to action. The man who thinks and feels, but does not translate his ideas and emotions into action, is hamstrung by doubt; he is unable to choose among the several possibilities presented to him; out of the mass of possible actions he has not been able to choose one, and so his true self does not stand revealed. His powers of expression are "sicklied o'er with the pale cast of thought." Behaviorism believes that "by their deeds ye shall know them." However, I would remind you, in passing, that failure to act in the ordinary sense is itself action. A body comes to rest only because the forces that act upon it are for the time being in equilibrium.

* Lecture given in the training course for community workers, Columbia University, New York, September 30, 1920.

R. M.

It is from this behavioristic standpoint that I have been asked to speak to you and to outline the general approach and fundamental assumptions of psychology—from the point of view, in other words, of man in action, or, as I should prefer to say, of man as a complex of action systems. In order that you may get my point of view, I will devote a few words to a historical restrospect of the factors that led up to the behavioristic movement in psychology.

The behavioristic psychology was one of those forward-looking efforts which were calculated to get beyond the concepts of the old academic, metaphysical type of psychology of a generation ago, and it was not satisfied by the physiological approach to its problems introduced by the Wundtian school. It was dominated by the need to get away from the necessity of dealing with involved introspections, which so frequently quickly gained a metaphysical ground, for it saw psychology as one of the biological sciences, not confined by any means to *homo sapiens*. The biological point of view necessarily involved the study of psyches other than human and made, therefore, the objective approach a necessity. In the study of animal psychology, the subject could not be interrogated in the usual way, but could be studied only in action, and thus there grew up that observational method which later came to be applied to man. This behavioristic attitude has distinct advantages and has been a useful variant in the course of psychological progress; it was a distinctly warranted new method because the old academic psychology had become sterile when it came to having anything helpful to offer in the solution of man's vital problems of living. It had nothing to say when it came to face his actual, practical problems, nothing to offer that was helpful in solving his difficulties or even in explaining their nature. It had come to be essentially a laboratory discipline occupied largely with questions of neuro-physiology and the physiology of the special sense organs.

The outstanding fact—the fact that the behavioristic viewpoint threw into high relief—is the fact that organisms are constructed on a pattern which has action for its purpose. Life itself has been defined as consisting of that constant back-and-forth flow of energy which constitutes the relation of

the organism to its environment. Every change in the environment must be met by an adjustment on the part of the organism, and that adjustment involves action, or, expressed in physiological terms, reaction. The adjustment effected brings the organism into functional contact with the environment at more points than before and therefore necessitates further reactions of adjustment, the growing number and complexity of which constitute development in the individual and evolution in the race.

This fact alone justifies the emphasis of the behaviorists on conduct, and what you as community workers will have to deal with in essence will be the failures of individuals to meet the conditions imposed upon them by their environment, largely their social environment—to effect adequate reactions of adjustment. You will see the results of actions that were calculated to make such adjustments, but have, for one reason or another, failed more or less completely. The criminal, for instance, is one who, in order to meet certain requirements of his nature and at the same time retain a certain social standard, acts in a way that is more or less out of harmony with social standards and to that extent fails to effect an efficient adjustment. His social standards, to be sure, are not those of the law-abiding citizen, but they spring from the same motives. He needs to provide for himself and family, so he steals; he is proud or rather vain, so he wears loud clothes; he likes to be looked up to by his associates, so he effects bravado and strives for skill in his particular line of work.

The great change that has come over psychology in recent days is that it has been humanized. In the days when psychology was metaphysical and academic, it was a subject for meditation in one's study; it had, strangely, almost no touch with the living, pulsing problem of human life. It was more interested in discussions of the nature of the soul than in such questions as why men failed in life. Failure of any kind was hardly recognized as a biological problem of adjustment, and so its real psychological significance failed of appreciation. Now, however, the whole tendency has changed, and it is just such problems as the criminal, the insane, the defective, the vagabond, the prostitute, the neurotic, and all sorts of minor disabilities that interest it most, and these are the same problems that occupy the focus of your attention.

To come to the question of the Why of some of these failures and your relation to them, to revert to the fundamental behavioristic conception of man as a complex of action systems or action patterns, one of the very obvious reasons for failure lies in the fact that the machinery which a man has at his command—and by this I mean his bodily machinery, his vital organs in all their complexities and intricate interrelations—is inadequate to the carrying out of a socially acceptable life plan. Bodily illness of one sort or another, chronic and disabling diseases of the vital organs—the heart, the lungs, the kidneys—make the demands of his environment beyond his powers of adjustment. An astonishingly large percentage of the unfit, the social outcasts, are seriously handicapped by bodily disease, while approximately 50 per cent, I think, of all classes are as seriously impaired by obvious or comparatively easily discoverable mental disease. What has a behavioristic psychology to say to this fact? In the first place, the two classes are not so widely separate as my statement would lead you to believe. The metaphysical distinction between mind and body, which still persists in many quarters, would lead to a definite separation. From the behavioristic point of view, which is concerned only with conduct, they would both appear as groups that failed to meet their problem of adjustment efficiently. The court of last resort, which passes upon all the issues of life, is the psyche, and the psyche has failed in both instances. Physical disease merely introduces a specific form of problem to be met, and the individual has been mentally incapable of handling it. We all know instances of men who have become beggared because they have lost the use of an arm or their sight, but we all also know instances of men who have risen superior to such disabilities and succeeded despite them, while some of us may know of those who have even succeeded because such misfortune has come to them. We have passed out of that stage of evolution in which success was solely a matter of blood and brawn, strength to kill or fleetness to escape, and are living in a period in which the struggle for survival, for success, is a contest of wits, a matter of brains. Therefore we may look upon failures of adaptation as predominantly failures at the psychological level. Here you will see I have

grouped all maladjustments, whether they be of apparently physical—that is, bodily—or of mental origin, as finally psychological. This may seem a rather extraordinary thing to do, but it is justified so long as we look upon action as the final expression of the organism. The psyche is not something that has been added to man somewhere in the course of his development from embryo to adult, nor yet is it something that has been added somewhere in the course of the biological evolution of the species. Every organism, no matter how simple, even though it be only unicellular, has a head end that is the first to push its way into the environment. This head end is the central office, if you will, the center which operates to control and direct all the activities of the organism as a whole, as a biological unity, and serves as the final station where all its several parts are integrated for those functions in which it, as a unity, must needs engage. It contains—or rather it consists of, is made up of, is—the final collected integration of the action systems of all its parts. The organism is, therefore, something more than a collection of organs; it is a collection of organs that are related in such a way that they may all, like the several parts of a complicated machine, be brought into the service of a common purpose, and the head end is the device from which emanates the directing force for such integrated activities.

Body and mind, therefore, are in no sense separate, one from the other, they occupy no different temporal relations in development, the one has neither preceded nor followed the other; they have grown up and evolved together as part and parcel of the same thing, the one consisting of the parts, the other of the integrated relation of the parts.

Behavior, conduct, then, is seen to be of necessity the final expression in action of the whole, and so to have the importance that the behaviorists attach to it. Defects in the individual—whether they be of mental or of bodily origin, whether they depend upon mind in the first instance or are traceable and dependent upon some defect of an organ, such as blindness—ultimately find their expression in conduct.

This latter statement requires amplification. The failures with which you will have to do are all really failures that involve the individual in his social adjustment. They are not,

despite the fact that they often appear to be, solely individual affairs; they are defects at the level of adjustment between the individual and his fellows, or at the psycho-social level. It is because this is so that the large class of unfit are social problems. A defective individual, for instance, because of his defect is unable to measure up to the standards of behavior that are set by society; he is poor, ill fed, lives in unsanitary and crowded conditions, is more liable to become the victim of disease, which disease, under such circumstances, is more apt to spread; he suffers because of his privation and may turn to alcohol or to crime for relief. In his struggles to effect an adjustment, he turns to all sorts of activities that are antisocial, and so in innumerable ways becomes in his community a focus for moral and physical disease, which not only threatens him with destruction, but is also a serious source of danger, as a result of his acts and example, to others. He is distinctly out of alignment with the tendencies that make for social progress and thus becomes a menace to the community in which he lives. The defective spreads moral and physical contagion, and just as the science of hygiene had its inception in the effort to clean up the pest holes of the big cities and manufacturing centers because of their danger to the community, so mental hygiene has now come forward to eliminate or render harmless the menace of mental defect; and it is realized that much of the former evil is dependent upon the latter. Take, for example, the venereal-disease problem. This deals with a class of diseases that are peculiarly destructive and that are disseminated by the prostitute. Now we know that a large percentage of prostitutes are feebleminded, and so we are beginning to appreciate that one of the most hopeful single approaches to the venereal-disease problem is by way of a more effective handling of the problem of feeblemindedness in the community. You will notice how immediately, as soon as we begin to deal with a problem of mental deficiency, we find it showing its teeth at the social level, how soon behavior that is inadequate to effect social adjustments becomes a social menace.

The same thing is true of less manifest disorders at what is usually supposed to be the psychological level. Take, for example, the person who is more or less crippled in efficiency

as the result of a neurosis or mild psychosis. Such a person, living in affluent circumstances, may seem to do no harm, but as a member of a poor and struggling family, he soon becomes a serious burden that may easily spell the difference between comfortable circumstances and a continuous fight for the bare necessities. Even in the former case, a neurotic person in the household necessarily becomes a burden to some degree, and to that same degree detracts from the fullest usefulness of the others, who must spend time and energy in meeting the problems thus created. All this you see from the standpoint of behavior, conduct, as the final measure of effectiveness of the individual.

These illustrations of the relation of the individual to society suggest at once an analogy between society, as composed of individuals, and the description I have already given of the body as composed of organs. In fact, we are dealing here with a situation that is something more than just an analogy. Society would be a meaningless term if its component individuals were not related in some way, if each functioned independently. The organism could not long survive such a dislocation of its several part functions, and society would be in a state of anarchy if the direction and control of its institutions were destroyed.

Now society has always, heretofore, been primarily and, for that matter, solely interested in the conduct of its members, in their acts, and whenever it has found some one doing things that tended to its disadvantage, it has sought to put a stop to such acts with very little thought of the actor, the doer of the act. At one time, for example, and that not so very long ago, there were over two hundred offenses on the statutes in England punishable by death, and the statutes were not inoperative by any means.

This is the method of eliminating the source, and is the natural way to proceed at first when nothing is seen but the obvious connection between the destructive result and its immediate cause. It is as if you should consult a physician for a pain in your leg and he should at once relieve you of the offending member by amputation. That was the way society dealt with its criminals in those days. To steal anything of the value of two shillings was a capital offense. It is the way,

too, in which surgery has dealt—and, I have no doubt, is still dealing—with many of its problems. It is the easiest way—for the surgeon. For example, innumerable ovaries were sacrificed in my college days because the patient had pain in the ovarian region. Now we know that the pain, in many instances at least, was psychological. The surgeon was trying to cut out a psychosis. When, however, the functions of the ovary came to be better known, it was realized that the cure was often worse than the disease, and so the practice ceased. What would you think of a watch maker to whom you took a watch with a broken mainspring and whose remedy was to remove the spring?

The same thing, however, has happened here as elsewhere. With increased knowledge, there has come a realization that there are other ways to tackle the problem that are more rational and bid fair to attain better results. The tendency in dealing with the delinquent, defective, and delinquent classes to-day is a tendency toward a greater individualization, a tendency to become more intimately acquainted with each individual problem, to deal, in other words, with the actor rather than with the act.

You community workers are like the trouble man employed by large business concerns. When any trouble arises with a customer—failure to deliver goods ordered, failure of goods to come up to quality agreed upon, dispute over the items in a bill—the trouble man is sent for to effect an adjustment. It is the same in the machinery of society as it is in the machinery of business. Whenever the machine does not work well, whenever there is lost motion, hot bearings, or a broken part, some one is sent to repair and adjust it. Now it is just about these inefficients that defects in the social machine come to view. They are the weak points in the mechanism, and so, when anything goes wrong, it is more apt to go wrong about them than anywhere else because they are less able than the other parts to bear the stresses and the loads of social demands. It is your job to see if some working compromise can be effected, some adjustment that will be socially acceptable at least, if nothing more.

Now as to the matter of effecting the necessary readjustments. Up to this point it is evident that the matter of ad-

justment is one of the mechanistics of the relation of the individual to his fellows, his community. But what kind of an individual is it that gets so out of touch with his community? A study of his conduct, his behavior, will indicate that he is, in some way, an undeveloped person—one who, in his conduct, manifests ways of adjustment that are, relatively speaking, infantile. The whole problem of the dependent, defective, and delinquent classes is, to my mind, most helpfully looked at from this point of view, as exhibiting undeveloped types of reaction, reactions whose inadequacy lies in the fact that they are relatively infantile. We have to deal, therefore, with a group of people who need to be helped to grow up. They do not need education in the ordinary sense of schooling, but they do need guidance and direction along the pathway that leads to more adult standards of behavior. What are some of the assumptions with which we must approach this effort?

In the first place, it is a fair assumption that every one desires to do better than he is doing. He not only wants to be more successful, but he wants to stand higher in the esteem of his fellows, even though his fellows may not represent a high standard of social efficiency. We must assume this because the very structure of society is based upon this forward-reaching tendency—yes, even life itself is expressive of this striving. Secondly, it is necessary to study the situation as thoroughly as possible in order to be able to define wherein the defect consists. The real defect may not reside at all where it seems to. An ineffective person may present evidences of a profound neurasthenic state coupled with tremendous ambition and bright ideas, when in reality the key to the situation is disclosed in the fact that he is a drug habitué. Then finally it is necessary to study the individual himself, in order to discover the nature of the difficulties within him that make for his poor social adjustments.

It is at this point that I part company with the extreme behaviorists, who would discredit the internal evidence entirely. It is true that "actions speak louder than words," and that when an action does occur, it is itself the best evidence of what the actor at that moment is, but it is a long way from this statement to the ability to see in acts their

true meanings. Theoretically, to be sure, one should be able to do this, and some day perhaps it will be possible, but in the meantime there can be no objection to finding out what the internal evidence has to offer. Truly this evidence is itself not necessarily any easier to read than the act, but it is so much in addition and is helpful to that extent and also because it furnishes corroboration or otherwise of the other evidence. It should not be lost sight of that a very important part of the internal evidence does not consist in introspection, but in the conditions of the internal organs disclosed by clinical methods of examination. The evidence derived from this source, no less than that from introspective sources, helps to an evaluation of the individual's equipment and to the disclosure of the nature of the disabilities under which he labors.

I have said that for the behaviorist what a person thinks and feels is of no significance and to society what a person thinks and feels matters not at all. It is only what one does that counts. A man may think all he likes of murdering his neighbor and he will never be arrested, but the moment he attempts it the authorities are after him. But psychologically, from the standpoint of the organism as a complex of action systems, thinking and feeling are but acts *in statu nascendi*. Many acts never get beyond the thinking and feeling stage, are never translated into conduct, and in connection with every one that is there are certain other, counter assertions, of opposing tendency, which, while they do not gain frank expression, are at least able to modify to some extent those that do. This arrangement by which conduct is the result of choice between opposing tendencies, each of which with varying force tries to avail itself of the machinery of expression, is the plan upon which the organism is built up. The athlete's muscles, if all extended or all flexed, would be useless to him in making those rapid movements upon which his skill depends; the heart, if it were not nicely balanced between an accelerating and an inhibiting mechanism, would be quite unequal to those quick responses, to the demands made upon it upon which life itself at times depends. It is the same with psychological tendencies. Progress is never unimpeded, obstacles always bestrew the path, difficulties must ever be overcome. It is true that the end product, conduct, bespeaks

the man, but it is essential, when conduct is inefficient, to know something of the internal obstacles that interfere.

I have said that with every act there is some other, counter assertion that is attempting to appropriate the means of expression. In this highly figurative way I have put the case for what the psychoanalyst calls the wish. All of these tendencies within the psyche which are struggling for expression are wishes in the sense of this school, and it is only by knowing what they are and their relative strength that a dynamic plat, so to speak, can be made of the personality. The wish to conform, to be well thought of by one's fellows, is practically always dominant, but behind each such wish there is another, antisocial, infantile in tendency, that also seeks expression. The first is almost sure to succeed, but the degree of its success is measured by the strength of the second. The soldier who was afraid to go forward was also afraid not to because of the discredit his failure would bring in the opinion of his associates. For the same reason he was afraid to run away. The dread of loss of social esteem was often sufficient to overbalance a fear that was not strong enough to be controlling, and he went forward. But for some the fear of going forward was so great that it was impossible to do so. Equally, death faced them in the form of a firing squad if they ran. The solution was, say, a neurotic paralysis of the legs which so crippled them that they could not walk, much less go forward or run away. The solution of the impasse was illness, but the illness itself was a concession to the social demands. Illness is respectable, cowardice is not. The soldier solved his difficulties in a socially acceptable way, but at the expense of a serious illness, which not only saved him from being shot, but crippled him so effectually that he was not good for much of anything, at least for a long time.

The behavior of our handicapped classes shows, therefore, a great desire for social esteem. The very illness that marks them as outside the crowd takes on a form which at once admits them as members. The necessity to conform is so great that one finds it lacking only in the severest and most malignant forms of mental disease and perhaps not altogether there. In passing, let me suggest that a tendency which manifests itself with such strength and so universally should be a

wonderful source of energy for good. Handled with wisdom, it should be a source of tremendous power.

Society, like Procrustes, demands that all shall come up to a given standard. It, too, makes a standard that few can achieve; we are all a little too long or a little too short for the Procrustean bed. But society is relentless and chops us off or stretches us out to fit, regardless of the injury inflicted. Society demands our last measure of adaptive power, and to the extent that we do not fit, to that extent we may compromise by the subterfuge of illness; we may pretend, but in the last analysis we must pay the price, which in the end is death, the final failure.

Now there are two approaches in helping to better inadequate adjustments. You may try to change the individual, as already indicated, or you may try to change the circumstances. The former particularly requires a certain attitude of mind in you which is essential to success. It is the attitude of the scientist. It is impersonal in the sense that it is not fraught with sentimentalism, which is dangerous, or with a sympathy that may be blinding. It requires an understanding based on knowledge and an unqualified desire to bring to pass a better state of affairs, untinctured by self-seeking motives.

In order that I may convince you of the importance of this state of mind, you must know that the antisocial wishes that find expression in conduct are unconscious to their host. Modern psychology has demonstrated that the larger part of our mental life, that portion from which comes all the motive power for conduct, lies beneath the threshold of what we ordinarily call our conscious selves. This is the region in which all that complex battle of motives occurs which ultimately surges to the surface and finds expression in actions of which we are aware. Therefore, blame is an unscientific and useless attitude with which to approach an attempt to effect any change in the results. Our antipathic emotions are only evidences that we ourselves stand in danger of similar lapses and have to bring all our feelings of blame and hate and disgust to bear upon them in order to protect ourselves from seeing in them anything that is desirable. Then again this organ of the unconscious is wonderfully sensitive and is aware, by that subtle process we call intuition, of any

unfriendly attitude in those about us. You must therefore learn to purge yourselves of feelings of blame, criticism, disgust, or similar emotions in approaching these problems. The difficulties of adjustment with which you will have to deal can not be helped by approaching them as if they were manifestations of original sin, or by talking down to the unfortunate in terms of specious platitudes. You will have to help to find better solutions than they have been able to, and help, too, in a spirit of understanding, with patience and by means of a superior knowledge. To do less than this is to attempt a correction by the use of undisciplined thinking which will fail at that point where, because of your personal limitations, you are unable to separate the wheat from the chaff. Success, therefore, will come to you in the degree to which you are able to weigh coolly, calmly, and dispassionately all the factors and throw the influence of your knowledge, your training, and your example and character in the balance on the side of better things.

Why, you may ask, should I discuss the attitude of mind with which these social problems should be approached? What can that have to do with the nature of those problems and their solution? Just this: You yourselves are parts of society, you are the instrumentalities through which it is sought to effect better adjustments. Now, just as an instrument must be fabricated for the work it is to do, so you must be shaped for the work you are to do. One would not try to repair a watch with a crowbar or to cut butter with a mallet. You, as instruments of society—as tools if you will—must be forged of good metal, be delicate enough in construction to deal with delicate situations, strong enough where strength is necessary, and keen-edged enough to cut deeply into the facts and discover what lies beneath. This course is the process of your fabrication.

Now with reference to the environment. You must, of course, stand in the community as essentially constructive individuals, but you will constantly come across circumstances in which you will feel convinced that the existing machinery that has been evolved for the purpose of dealing with problems of social maladjustment is inadequate and works hardship and injustice. You should not passively accept this ma-

chinery as being perfect, but will be forced to a consideration of how it may be improved. Civilization, our civilization, has come by its traditions and institutions by divers and devious ways. Some of the accepted standards strike very deeply into the nature of man, flesh of his flesh, bone of his bone, but others sit very lightly on the surface. If you will study the construction of primitive society, you will realize that the people we call savages are already at a very high point of social development, that their institutions have a long history and that their organization is very complex. One comes from such a study, which indicates how man has been blindly groping through the ages by a sort of hit-and-miss process, a method of trial and error, wondering whether after all our solutions are necessarily all upon the right track, and inclined to more or less sympathy with a recent writer who closes his book with the following: "To that planless hodgepodge, that thing of shreds and patches called civilization, its historian can no longer yield superstitious reverence. He will realize better than others the obstacles to infusing design into the amorphous product; but in thought at least he will not grovel before it in fatalistic acquiescence, but dream of a rational scheme to supplant the chaotic jumble."

Let me give you an example of how existing machinery creaks in its bearings. A colored boy was incorrigible as a youth. He grew up to adolescence and took to alcohol. He began to be arrested for all sorts of crimes and accumulated a varied and lengthy police record. He served time for petty crimes, for assault, and a long term for burglary. He attempted to kill his wife, and tried to consummate bigamy under a threat to shoot the girl if she refused to marry him. He stabbed one man, acquired the drug habit, and habitually toted a gun when he was drunk and was known as a bad man. He had been passed upon by the local psychiatrist as a psychopathic type of some sort. In other words, he had advertised himself as widely and emphatically as he could as headed for more and increasingly serious acts of a criminal nature. He came and went in and out of jail and prison and finally committed a homicide. Then he was hung. How wasteful and how inefficient and stupid the whole procedure seems in retrospect, and yet that is about the way the machinery works

on the average. It is such inadequacies that need correcting, and it is through the careful studies and the accumulated experiences of such work as you are fitting yourselves to perform that more practical methods will be evolved for dealing with the social problems that are presented by such types of individuals.

Human nature has been in process of evolution a very long time. The period covered by history represents only a very short part of the time during which the process has been going forward. The differences between people are very much less than their resemblances, and those differences are in degrees of equipment, which make some a little better able than others to handle their problems. All have at their best something worth while, a percentage, be it ever so small, of efficiency, if only the circumstances are not made too hard. For these problems of society modern psychology, with your help, is to find that adjustment which will most nearly enable people to develop their good points to the uttermost, which will help them to be of the maximum social value within their limitations. Mere repression can solve only part of the problem; beyond that is needed intelligent encouragement and assistance to do better.

And speaking of repression reminds me to say just a word regarding punishment. Punishment is theoretically inflicted as a repressive measure both upon the criminal and by way of example upon those who might become criminals. From this point of view, it is manifestly very largely a failure. It needs to be used after the manner of the conditioned reflex about which the behaviorists write so much. It needs to be scientifically studied, so that it may be used to make the wrong path undesirable, and coupled with an adequate system of training and development, to make the right path more attractive. No one can know the criminal classes without realizing how little they really get out of their way of living that gives satisfaction. But their childish make-up renders that continuity of effort which spells success for most of us impossible for them. They should be assisted to develop this possibility and helped to find activities that are sufficiently interesting to stimulate and maintain it. You should be the clear-minded, disciplined thinkers of the community to whom it will learn

to turn for information that will be of service in dealing with all these difficult social problems.

This is the method, you will see, of attempting to make available the energies of the individual to the best advantage. It is quite different from hanging a man because he has stolen two shillings, cutting off his leg because he has a pain in it, or discarding a broken part of a machine and putting nothing in its place. It deals with the human machine and with the social machine as with machines elsewhere—as means of utilizing energy. If a part is not functioning well, we attempt to repair the machine, not destroy it. If the part—the leg, the stomach, the brain, or what not—is out of order, we try to fix it so that it will be as good as new; if this cannot be done, then the next best thing is to try to change the kind of work in such a way that the weakened member will not interfere so much with the results—in a way that will remove the excessive strain from the weak part. If the individual cannot be changed, perhaps the circumstances can.

Let me illustrate more concretely what I mean. The average individual who is seriously defective mentally is to-day practically a total loss to the community. In fact, he is more than just a loss—he is a source of loss in others. He can be rated only as a liability. Now we know, as a matter of fact, that a large number of the feebleminded can be educated and trained within certain limits, are good-natured, industrious, faithful, and reliable—in other words, that they possess qualities that would make them of considerable use if their energies could be consistently directed within their limitations. In fact we all have our limitations and can function to best advantage only when we keep within them. I am convinced that if this principle could be generally accepted, a large proportion of human material which now has to be rated as a total liability could be made an asset, not only from the point of view of society, but from that of the individual himself.

One of my colleagues has suggested that, if large factory owners could be made to understand this, and would provide a special environment for them, a very considerable number of the feebleminded of a factory community could be usefully employed and so kept at home and saved an institutional

existence. I am not unmindful of the possibilities for evil in such a scheme. I only point to the possibilities for good.

I was asked to talk to you on the behavioristic attitude—the general approach and fundamental assumptions of modern psychology. I have said a great many things to you in the hour. Let me close by bringing together the main points I have tried to make, by summing up the fundamental assumptions of modern psychology, which it has to offer you on the eve of your entry upon your chosen field of work.

1. The organism is a complex of action patterns.
2. Man *is* what he *does*.
3. Perception, thinking, and feeling are but actions in process of becoming.
4. Action is really reaction in the process of adaptation.
5. The process of adaptation *is* the process of development and evolution.
6. All action implies tendencies and counter tendencies, and what issues depends on their relative strength at the time.
7. Therefore, what a man does he *wishes* to do.
8. The psyche is the head end of the organism and its history is the history of the relations of the organs.
9. The psyche *is* the final grouping of the action patterns, integrated to serve the organism in its functions as a unity.
10. The motives that lead to a-social and antisocial conduct are relatively undeveloped and infantile.
11. These motives lie in the unconscious.
12. Modern psychology places great emphasis upon the unconscious.
13. Society is an organism.
14. Maladjustment is always a psycho-social problem.
15. Its correction may be approached by trying to change either the individual or the environment, or both.
16. Changing the individual requires a knowledge of the internal evidence to elucidate the nature of his personal difficulties.
17. The internal evidence includes the evidence from the unconscious and the evidence from a clinical examination of the bodily organs.
18. Changing the environment is calculated to adjust it to the limits of the individual.

19. The environment includes social institutions that are far from perfect.

20. Repression and elimination are only negative ways of procedure.

21. Punishment needs to be studied scientifically as a means for conditioning conduct.

22. A positive attitude of education and helpfulness is needed in addition.

23. The principle involved is that the individual and society are like machines composed of parts. The attempt should be made to bring the parts into more harmonious mechanistic adjustment to the end of a better utilization of the energy.

24. The problem should be approached in a scientific frame of mind. Sentimentality is and sympathy may be dangerous, antipathic emotions are distorting, understanding and wisdom are essential.

25. You are the trouble men of the social corporation and should be looked to for the clear and disciplined thinking, based on knowledge from your experience, that will be of aid in bringing about better conditions.

A SURVEY OF THE TEACHING OF MENTAL HYGIENE IN THE NORMAL SCHOOLS

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"THE one unthinkable thing in American education is uniformity," said Samuel Thurber some years ago. The characteristic diversity of American education is naturally found in the training schools for teachers as well as in other educational institutions in the United States, although there is a solid nucleus of conventional work in their programs. This diversity extends to the curriculum, the length of the course, and the personnel of the schools. Hence few important quantitative data for statistical study are available, but the qualitative data are significant. The facts in regard to the various schools and the teaching staff are given in the annual bulletin published by the Bureau of Education.[1]

During the last academic year the following questionnaire was sent by the National Committee for Mental Hygiene to the public and private normal and training schools throughout the country:

1. Is any regular course in mental hygiene given in your school? If so, what is the character of the course and how much time is devoted to it?

2. Is any *special* course in mental hygiene given in your school? If so, what is the character of the course and how long a time is devoted to it?

3. Is any part of the field of mental hygiene taught in connection with the courses in psychology? If so, what topics are presented and how much time is devoted to the subject?

4. Is any part of mental hygiene taught in connection with the course in child study in your school? If so, what topics are taken up and how much time is devoted to the subject?

5. Is any part of mental hygiene taught in connection with school hygiene in your school?

6. Is any part of mental hygiene taught in connection with any other courses in your school?

7. Are any courses in practical training of teachers in testing the mental ability of children or in visiting institutions for the

[1] Educational Directory, 1919-20. Part 3. Washington: Bureau of Education Bulletin, No. 71.

feebleminded and defective or any other form of practical instruction given in your school?

8. Are courses given in your school planned to prepare teachers for ungraded (mentally defective) classes in the public school?

9. Remarks: Any information that you can give in regard to the status of this subject in your school, the books on the subject in your library, the interest of the teachers, or any other matters of importance in regard to the subject.

Results of the Survey

Replies were received from about 175 normal and training schools in various parts of the country. These schools have an enrollment of over 40,000 normal students, one-fifth of whom are men. The answers are sufficiently numerous and the schools sufficiently representative to render the results thoroughly reliable.

1. As regards the first question, it appears that very few regular courses in the subject of mental hygiene are given in any of the normal or training schools. One hundred and thirty-seven, or 78.09 per cent of all those reporting, state definitely that no courses in this subject are given. A few noteworthy exceptions occur. The following quotations report work done in various schools. In many cases only special phases of the subject are taken up, and yet it is significant that regular courses in mental hygiene are reported.

W. W. Parsons, Indiana State Normal School, Terre Haute, Indiana: "Yes. Three months on major neuroses and psychoses and various forms of feeblemindedness. These are treated from the point of view of genesis, symtomatology, and treatment, also prevention."

J. R. Perkins, State Normal School, Danbury, Connecticut: "Defects of hearing, vision, speech, and mentality are considered. The objects of this work are to instruct teachers in what sorts of deficiencies to look for, what signs may indicate these, and what they should do when suspected cases come to their attention. Methods of determining deficiency are discussed, and ways of dealing with such deficient children as must remain in regular classes of normal pupils."

2. To the second question the larger part of the schools — 127, or 72.57 per cent—report that no special courses in mental

hygiene are given. In a few schools, however, special lectures or courses are given. For example, the following:

Hyannis Normal School, Hyannis, Massachusetts: "Five weeks (50 periods) in summer session. Mental measurements."

New Mexico Normal University, East Las Vegas, New Mexico: "A course in mental testing and child welfare. Twenty-four weeks, regular textbook work with experimental exercises."

3. To the third question, the majority of the schools — 103, or 58.86 per cent — report that a part of the field of mental hygiene is taught in connection with courses in psychology. In most cases instruction in regard to very vital topics is given. The following are some of the concrete reports:

Atlanta Normal Training School, Atlanta, Georgia: "We study, as carefully as is possible for us, the different children in our special class from the standpoint of child study. About ten lectures are given each year on such subjects as: Some Causes of Feeblemindedness; The Relation of Physical Health to Mental Health; Different Types of Children to be Found in the Average Grade of a City School; What Should a City Do for its Handicapped Children; A Study of the Jukes and Kallikak Families; What Could a State Do to Reduce Feeblemindedness? These talks are accompanied by assigned readings. We have a *little* literature."

Boston Normal School, Boston, Massachusetts: "Yes. The idea of physical and mental health is considered incidentally throughout the course. In his lectures, the instructor makes use of several of the published articles of Dr. Burnham. Some ten periods of forty minutes each are devoted to the nature and application of general intelligence tests."

Kansas State Normal School, Emporia, Kansas: "A discussion of how to study and of economy in mental work is taken up in Psychology I and II. From three to six recitation hours are given to these topics."

New Mexico Normal University, East Las Vegas, New Mexico: "Yes. An effort to connect the principles of psychology with the personal efficiency of the student is made at all parts of the course of thirty-six weeks in psychology. Such topics as habit, control of attention, etc."

State Normal School, Newark, New Jersey: "The growth of the school compelled me ultimately to concentrate on the department of psychology, but in its application I still treat upon a number of these topics.

"The integration of the nervous system, the motor character of consciousness (as many as six periods spent on the third paragraph of Chapter XXIII in James' Briefer Course), instinct, emotion, will, the self offer, perhaps, the most obvious suggestions for hygiene. The student is aided in analyzing situations and in making inferences. A few topics taken at random may make clearer the trend of the work:

Iterative rhythms, why undesirable; Difference between daydreaming and imagination; Sleep: immediate, healthful modes of securing; Dreams: sex element not brought in, but prophylactic measures suggested; On putting children to bed; Types of play activity."

State Normal School, Worcester, Massachusetts: "Yes. Among the topics covered in our courses in psychology and child study are the chief instincts, with a discussion of their proper training and guidance; the great human emotions, particularly the fears and phobias, with their roots often if not always in malpractices on the part of parents during childhood; the will and moral development in each of the periods of life—infancy, childhood, and adolescence; improper stimuli and their inevitable consequences in terms of juvenile delinquency; the inevitableness of heredity, with special comparative studies of the chief studies thus far made, such as the Kallikak family, the Jukes, the Edwards-Tuttles, Galton, etc., with emphasis upon the practical conclusions drawn; eugenics and euthenics; plasticity and habit; causes, extent, and disposal of mental defectiveness, with a classification of defectives and a discussion of their relationships with the public schools; a study of the unstable child; physical and emotional characteristics of psychoneuroses and their causes, epilepsy, hysteria, dementia praecox, chorea, habit-spasms, etc."

4. As regards the fourth question, a considerable number — 78 schools, or 44.57 per cent — report that work in mental hygiene is given in connection with the course in child study. In some schools important work is here presented, for example the following:

Florence State Normal School, Florence, Alabama: "Yes, growth and development; fatigue in learning; maturity, learning and ability; general and special training. We experiment and observe to verify our text. About three months."

Kansas State Normal School, Emporia, Kansas: "About one-fourth of the time in a two-hour course in child psychology is given to topics in mental hygiene. Backward, superior, and exceptional children are studied; the development of correct moral habits and ideas in early childhood, mental conflicts, control of emotions, etc., are studied."

5. As regards the fifth question, the majority of the schools report that no part of mental hygiene is taught in connection with school hygiene. Sixty-two, or 35.43 per cent, however, report that some part of the field is taught in the school-hygiene course. The following are significant examples:

> Dunn County Training School for Teachers, Menomonie, Wisconsin: "Incidentally. Our teacher gives a course of treatment by lectures to get right thinking on social questions. One lecture a week."

> Huntington College, Marshall, West Virginia: "Yes. Those presented in Terman's *Hygiene of the School Child*. The nervous child; common neuroses of development; the education of the nervous child; speech defects; the sleep of school children; some evil effects of school life."

> State Normal Training School, Willimantic, Connecticut: "Junior class: In planning a hygienic school program those conditions are studied which tend to healthful mental habits, and the reverse are discussed.
>
> "Senior class: Eight class periods devoted to the problems of mental hygiene. Topics in chapters, Terman, *The Hygiene of the School Child*."

6. To the sixth question, the majority of the schools report that no part of mental hygiene is taught in connection with other courses. It does appear, however, that in 41 schools, or 23.43 per cent, some instruction in mental hygiene in connection with other subjects, such as social science, physiology, biology, or the like is given.

> New Mexico Normal University, East Las Vegas, New Mexico: "A special course in psychoanalysis is given, covering twelve weeks' time."

7. As regards the seventh question, 94, or 53.71 per cent, of the schools report that courses in practical training of teachers in testing mental ability and the like are given. The following are illustrations:

> Colorado State Normal School, Gunnison, Colorado: "A course in the measurement of intelligence is given. Students in this course are expected to become familiar with the elementary theory of mental tests and to have practice both in group and in individual methods of testing intelligence."

New Orleans Normal Training School for Teachers, New Orleans, Louisiana: "A course of lectures on testing the intelligence, Binet-Simon tests demonstrated, is given to seniors by psychology teacher. Visits to schoolroom of feebleminded children in graded school. The testing of these children. Also tests of the deaf and dumb classes. A course in educational measurements, description and experiments and explanation of standardized tests in school subjects. Examination of school reports and surveys. Interpretation of these."

State Normal School, Bellingham, Washington: "Mental tests given for purposes of demonstration of children's mental reactions, before classes in child study. Mental tests given to children in training school at request of supervisors. Course in theory and use of mental tests given in summer quarter. Our use of mental tests not with special reference to feebleminded or training of teachers of feebleminded. Show their use in the average school."

State Normal School, Newark, New Jersey: "We take our classes to visit the medical department of the schools when tests of mental ability are given, and also to visit defective classes. And we cause them to make reports on what they there observe."

West Texas State Normal College, Canyon, Texas: "Mental tests and measurements. This course is designed for preparing students to give these tests, such as are standard; accordingly much time is spent in the study of mental tests and their actual application to subjects. In addition, much time is spent in the study of the present movement toward mental measurement as found in school systems and psychological clinics. Some attention is given to such investigations of exceptional children as will assist the student in his grasp of the meaning and significance of the measurement of intelligence. Three term hours."

8. As regards the eighth question, very few schools — only 25, or 14.28 per cent — report any courses especially planned to prepare teachers for ungraded or mentally defective classes in the public schools. The following are concrete reports:

Louisiana State Normal School, Natchitoches, Louisiana: "We have arrangements under way for the establishing of an educational clinic and psychological laboratory. A course in the exceptional child will be offered in the summer session, and regular systematic work along practical lines will be taken up at the beginning of the fall term. Five hundred dollars' worth of apparatus and materials will be installed between now and the opening of the summer term, and several hundred dollars' worth will be added

before the opening of the fall term. Our plan is to include a regular series of experiments in connection with Psychology 1 and Psychology 2 and institute special clinical work in the training school, looking forward to the establishing of a special room. This will eventually lead to the training of a few teachers of special ungraded rooms. All the leading books in this field are either now in the library or will be ordered in the near future. Also journals will be included which treat of this special work."

Newark Normal School of Physical Education and Hygiene, Newark, New Jersey: "No. We hope at most to make our graduates conscious that if, in their future work, they are appointed to mentally defective classes, they must devote themselves to special study of the question. That is to say, they will not be ignorant of the fact that they are ignorant of the adaptations necessary in their practice."

State Normal College of the University of Montana, Dillon, Montana: "Only in a limited degree. A few of our pupil teachers have become successful teachers of such classes."

State Normal School, Florence, Alabama: "Yes; for ungraded, but not for 'mentally defective.' Ungraded schools in this country do not mean mentally defective."

State Normal School, Montclair, New Jersey: "We train for the public schools. But our students in genetic psychology cover ground that fits them to take special courses at Columbia, New York University, the Vineland Training School, and elsewhere."

9. To the request for information in regard to the status of mental hygiene, the books used, and the like, many instructive answers were received. The interest in the subject, the desire for help, the attitude of the teachers, the demand for literature, the aim of the instruction, the needs of the normal schools in this field, as well as the difficulties that are met, are well shown by the following citations from the remarks made by various teachers:

City Normal School, Patterson, New Jersey: "A wide interest in mental intelligence tests—by teachers and students. A great deal of help sought in sifting out special cases. Much individual work given in efforts to restore pupils who have fallen behind, but are *not* defective."

Jamaica Training School for Teachers, Jamaica, New York: "Little attention has been given to the subject. The teachers are

held pretty strictly to the material in the city course of study for training schools. Any change would have to come from the central authorities. At present the curriculum contains more than can be effectively done by the average student, and the introduction of any work, however desirable, would demand a revision of the course of study, which could be done only by the central authorities. I should be glad to receive any literature on the subject which might aid me not only in understanding more fully the character and extent of the work which might be done, but as aid to at least some incidental work in that line in connection with my regular work in psychology."

Newark Normal School of Physical Education and Hygiene, Newark, New Jersey: "We are interested to know how much time, and to what extent, the Committee for Mental Hygiene would recommend the subject to be taught in a regular physical-training normal school. We will always be ready to further the work of your committee and would be greatly obliged for any literature you might be able to send us in the program you are planning."

State Normal College of the University of Montana, Dillon, Montana: "Outside of Goddard's and a few other books, none in the library; teachers have no special interest in the subject."

State Normal School, Duluth, Minnesota: "So far the attention given the subject generally has been limited to the opportunities afforded in carrying on the regular work. This does not mean that it has had little attention, but rather that it has seemed to be the best way to handle it."

State Normal School, Florence, Alabama: "A number of teachers are much interested and we are planning to use Terman's book next term. Any help will be greatly appreciated."

State Normal School, Gorham, Maine: "Nothing in library except the new works on child psychology such as Norsworthy and Whitley and Waddle. A little special magazine literature. The interest of the teachers in mental tests is exceedingly good."

State Normal School, Keene, New Hampshire: "We wish all the possible help we can get on practical methods and devices for teaching backward and defective children."

State Normal School, Newark, New Jersey: "It consciously underlies all of the work in psychology, one-third of the time, possibly, being devoted to mental dynamics and two-thirds of the time to its efficient direction. Several of the teachers trained in testing and also in handling different types and degrees of defect, with much skill in handling cases of nervous disorder (not insanity). Knowledge of psychoanalysis, but no *training* in its use. The splendid

equipment and hearty coöperation of the Newark Public Library have made it unnecessary to have a large collection of the works on this subject."

State Normal School, Plattsburgh, New York: "We have a number of well known books of the kind in our library, but none very recent. I am trying to make up a list that will be useful to the teachers and those preparing to teach. Anything technical would not be read. To be of use in our work, such books should consist as far as possible of plain statement (not over-statement) of accepted facts, not long discussions of matters still in dispute."

State Normal School, Salem, Massachusetts: "At least we teachers in the training department and the teacher of psychology in the normal department have made some preparation for this work. The library has a fair number of books in this special field."

State Normal School, Terre Haute, Indiana: "Outside of the department of psychology not much is done with the subject. The department of psychology would like very much to receive help in organizing a course in this subject. There is no question about the need of it. The source of material is the only drawback."

The private normal schools reported in the Educational Directory for 1919–1920 are largely schools for the training of teachers in physical education or industrial and agricultural schools. Some significant answers were received from a few of these schools. The following reports are examples:

New Haven Normal School of Gymnastics, New Haven, Connecticut: "We have no regular or special course in mental hygiene in our school. Our courses in psychology, education, physiology of exercise, and pedagogy of physical education all lay a foundation for right living from the standpoint of mental hygiene, but we do not give any special instruction in that line. Our seniors have some lectures in regard to defective children and have some opportunity for observing the work with defective children in the public schools in New Haven."

Sargent School for Physical Education, Cambridge, Massachusetts: "It is essentially the basis of our course on the relationship of mind and body. We feel that our physical work is, by its very nature, the best preparation for a sound mental outlook, and that with this ideal in view, our graduates are well equipped to spread the gospel of mental hygiene.

"The fact that for some years physical exercise has been recognized as an essential factor in awakening the sluggish mind and in

> stimulating the mental powers of defective and deficient children and adults increases our conviction that adequate physical training of the average normal child is one of the best means of putting into practice the theory of mental hygiene."

The general results of this survey may be summarized briefly as follows:

Few schools give any regular courses in mental hygiene.

Few give any special courses in mental hygiene.

Most of the schools have a certain amount of instruction in mental hygiene, often a very important amount, in connection with the work in psychology, child study, child hygiene, or other subjects.

Many schools give a good amount of attention to mental tests.

There is great diversity among the different schools as regards the attention given to the subject of mental hygiene. Some regard it as important and give much time to it; some regard it as important, but give little time; some do not recognize its significance; some apparently have no clear idea what it is; while some aim to give the new conception of health as a mental and moral as well as a physical condition. The amount of time devoted to this subject, even in the best normal schools, is inadequate. The work is usually scattered; the instruction is not always expert; and sometimes the common academic tendency to camouflage the facts is suggested.

Great interest and desire for help in the presentation of this subject are shown by many of the normal schools.

What is needed in many schools is suggested by the work done in the schools that give most attention to the subject.

To a large extent the old idea still prevails that mental hygiene has to do with the abnormal.

Some schools are beginning to see that mental hygiene is quite as important for the normal as for the defective.

The Most Significant Result

The one significant result of the whole survey, apart from the gratifying interest shown in the subject of mental hygiene, is the fact that what is actually being done in the normal schools gives the best suggestion and emphasis in regard to what could be done in all schools.

If a student could go from one school to another, say to half a dozen different schools where the best work is given, he would get a good course in this subject. If we could put together into one course in one school what is done in a score of the best normal schools in the courses of psychology and child study, we should have an admirable course in mental hygiene. Such a course would be, briefly, somewhat as follows:

Department of Physiology, State Normal School, Ypsilanti, Michigan: "I. Introduction; scope of the subject; references; some examples of emotional states reflected in bodily states.

"II. Internal secretions; general nature, illustrations of their influence; organs of: thyroid, thymus, pituitary, pineal, adrenals, gonads, pancreas. Hormones and chalones. Cannon, Chapters 1 to 8.

"III. The visceral nervous system. Howell.

"IV. The central nervous system. Laboratory study of neurones, cross sections of spinal cord, superficial anatomy of the brain.

"V. Reflexes.

"VI. The functions of the brain. Loeb: Instincts; associative memory, localization. Crile: The relation between the physical state of the brain cells and brain functions. p. 111.

"VII. A mechanistic view of psychology. Crile, p. 127.

"VIII. Phylogenetic associations and the emotions. Crile, p. 55.

"IX. The general laws of heredity.

"X. Neuroses. Freud.

"XI. The teacher and the parent as makers of character. Mental hygiene in the school and the home.

"XII. The relation between religion and bodily condition."

State Normal School, East Stroudsburg, Pennsylvania: "Striking variations of personality and mental hygiene and mental efficiency; variations of personality as related to the nervous system; what is the difficulty in cases of inadequate personality; nervous currents and resistances; neurasthenia and psychasthenia; bodily causes of mental variations; mental causes of mental variations; the subconscious; sleep and dreams; shifting personality; common types of insanity; our attitude toward the peculiar personality; the new ideal in education; rules of physical (bodily) hygiene; rules of mental hygiene; what ails the unhealthy mind? Maladjustment during school days; fatigue, bodily and mental; signs of fatigue and weariness; training for efficiency; principles of mental efficiency; what can the teacher do?

"It is difficult to state exactly the time given to these topics, especially as some of them come up again and again during the course. I try to give them sufficient treatment so the student can make practical application of them."

State Normal School, Terre Haute, Indiana: "Instinct and Development. Proper development or treatment of instinctive ten-

dencies; normal development and growth in contrast with forced, overstimulated, overemotionalized—e. g., fears; Adler's feeling of inferiority; Terman's *Hygiene of the School Child*, chapters on mental hygiene.

"Mental Hygiene of Childhood. The subnormal, the supernormal child, and the nervous child; the fears of children, their genesis and prevention; the establishment of correct reflexes and associations in early childhood; suggestion, its use and abuse.

"Tests of Intelligence. A course in testing mental ability. Students do some actual testing, look up back histories, make special diagnosis of abilities and disabilities, and suggest treatment."

Cleveland School of Education, Cleveland, Ohio: "Principles of Mental Hygiene for Normal Children. The hygienic significance of the mental attitudes. Mental conflicts. Fear in relation to the mental health. Mental conditions in the normal that simulate feeble-mindedness."

This course is not the best that could be arranged, but it is a good course and it is entirely a practical one. This is indicated by the fact that the various parts of it have actually been tested in the courses given in various schools. The only question is the question of time, relative value, and the possibility of competent teaching. Is such a course worth while? Is there anything really significant in mental hygiene for the teacher? The returns received give a pretty strong affirmative answer to this question.

The value of such a course in mental hygiene as that outlined above, combining the work done in various schools, is suggested by the following bibliography selected from the books now used in the various schools:

Bibliography of Representative Books Now Used in Various Normal Schools

1. Ayres, L. P. Laggards in Our Schools. New York Charities Pub. Comm., 1909. 236 p.

2. Binet, A. and Simon, H. Les Enfants Anormaux. Paris: Colin, 1907. 211 p.

3. Breckenridge, S. B., and Abbot. The Delinquent Child and the Home. New York Charities Publ. Comm., 1912. 355 p.

4. Burnham, William H. Mental Health for Normal Children. Publication of Massachusetts Society for Mental Hygiene, 1917, 8 p.

5. Burnham, William H. Success and Failure as Conditions of Mental Health. Mental Hygiene, Vol. III, pp. 387-397, July, 1919.

6. Clouston, T. S. The Hygiene of the Mind. London: Methuen, 1906. 284 p.

7. Cornell, W. S. Health and Medical Inspection of School Children. Philadelphia: Davis, 1912. 614 p.

8. Forel, A. H. Hygiene of Nerves and Mind in Health and Disease. New York: Putnam, 1907. 343 p.

9. Goddard, H. H. Feeblemindedness, Its Causes and Consequences. New York: Macmillan, 1914. 499 p.

10. Guthrie, Leonard G. Functional Nervous Disorders in Childhood. London: Frowde, 1907. 300 p.

11. Henderson, C. R. An Introduction to the Study of the Dependent, Defective and Delinquent Classes. Boston: Heath, 1901. 397 p.

12. Hough, T. and Sedgwick, W. T. The Human Mechanism. Boston: Ginn, 1906. 564 p.

13. Mosso, Angelo. Fatigue. New York: Putnam, 1904. 334 p.

14. Offner, M. Mental Fatigue. Baltimore: Warwick and York, 1911. 133 p.

15. Osborne, C. A. The Sleep of Infancy as Related to Physical and Mental Growth. *Pedagogical Seminary*, 1912, p. 1-47.

16. Rachford, B. K. Neurotic Disorders of Childhood. New York: Treat, 1905. 440 p.

17. Sandiford, P. Mental and Physical Life of School Children. New York: Longmans Green, 1913. 346 p.

18. Scripture, E. W. Stuttering and Lisping. New York: Macmillan, 1912. 251 p.

19. Seashore, C. E. Psychology and Daily Life. New York: Appleton, 1913. 226 p.

20. Shuttleworth, G. E. and Potts, W. A. Mentally Deficient Children. London: Lewis, 1919. 236 p.

21. Terman, Lewis M. The Hygiene of the School Child. Boston: Houghton Mifflin, 1916. 362 p.

22. Terman, Lewis M. Measurement of Intelligence. Boston: Houghton Miffin, 1916. 362 p.

23. Tredgold, A. F. Mental Deficiency. London: Baillière, Tindall and Cox, 1914. 491 p.

24. Wells, F. L. Mental Adjustments. New York: Appleton, 1917. 331 p.

25. White, W. A. Principles of Hental Hygiene. New York: Macmillan, 1917. 323 p.

26. Literature of the National Committee for Mental Hygiene, 50 Union Square, New York City.

27. Literature of the Massachusetts Society for Mental Hygiene, 1132 Kimball Building, Boston, Massachusetts.

Comments and Criticism

The replies to these questions are very illuminating, not merely for the direct answers given, but also as showing the attitude of intelligent people toward the subject of mental hygiene. The strong interest in the subject and the desire to

do more in this field as soon as possible are gratifying, and to some will be surprising. Although the work is done chiefly in connection with other subjects, like psychology, child study, and child hygiene, it is recognized as important and evidently makes its appeal to the students.

In some schools, apparently, there is great interest in the subject, work has already been begun, and the aim is to increase the attention given as soon as opportunity offers and suitable literature is available. The following report from one school is a noteworthy illustration of this interest. The work was begun two years ago with tests of accomplishment in subject matter and intelligence tests, according to the Terman revision. The teacher reports that the work has gone far enough so that she can speak in regard to the practical application to school work in the normal schools, and adds, "We are just about to enter upon a more elaborate adaptation of this work to our needs." As regards the aims and methods of the plan, the report is as follows:

> "1. Instructors in methods of teaching subject matter acquaint their students with the accomplishment tests available for their particular subjects.
>
> "2. Supervisors direct the practice teaching in these subjects to test out the progress children are making in subject matter, by the use of the available tests. When these tests are made, the pupil teachers assist and keep permanent records.
>
> "3. The instructor in psychology presents to the students the possibilities of group and of individual mental testing, and gives demonstrations of both. (We give 25 hours to this work.)
>
> "4. The head of the practice school, with the assistance of the grade supervisor of each grade, gives mental surveys of the grades in the practice school, with practice teachers present. (We use the Pintner suggestions.)
>
> "5. The instructor in psychology does individual testing of pupils in the practice school, practice teachers assisting by scoring.
>
> "The teachers who graduate from our school understand the scientific attitude that has come into teaching. They should be able to give group surveys, both in intelligence testing and in testing for accomplishment in subject matter. They know what is meant by the individual testing, but we discourage their attempting it themselves, believing that they have not a sufficient background in psychology or in experience."

All our correspondents, of course, did have a general knowledge of the meaning of mental hygiene and did not show

any such gross ignorance as that of some in the community who stumble at the word or identify the subject with dental hygiene. But nevertheless some had a rather vague and uncertain conception of the meaning of the term, including in their answers, perhaps, such topics as heating, lighting, ventilation, and the like, or throwing the questionnaire into the wastebasket because they did not understand what it meant.

There is, however, general recognition of the importance of the subject, although some seem to think that bodily or somatic hygiene is more important, at least as the necessary foundation for mental hygiene. Mr. Kirk, of the Normal School at Kirksville, Missouri, writes as follows:

> "I always encourage neighbors in building a new house, even though some of them begin with the roof and have to hold their houses up with props in order to get foundations under the houses.
>
> "This teachers' college is doing the unusual thing by trying to start some foundations first and building the roof later. We have a department of child hygiene and public health. We recently installed some six thousand dollars' worth of special appliances for testing both children and grown-ups as to eyes, ears, nose, throat, teeth, lungs, nerves, sputum, skeletal conditions, etc.
>
> "We never knew before that good students and good pupils, good grown-ups and good children had such horrible malformations and abnormal growths and defects to hinder their mental development. Wonderful, wonderful are the ways of men, that yet may be devised and utilized for human betterment.
>
> "Of course we shall be obliged to move right on up into the measure inquired about through your questionnaire."

Parenthetically, the writer of this paper may say that many years ago he, too, began with the foundation of ordinary school hygiene and child hygiene, but soon found that one could not go far in the matters of personal and child hygiene without feeling the need of a knowledge of mental hygiene as well as of the ordinary hygienic structure. In other words, it appeared that to study school hygiene at all adequately, it was necessary to study the conditions that favor the healthful development of that part of the child with which the school is especially concerned — namely, the child's brain and the child's mind.

A survey of this kind can hardly fail to give the investigator some insight into the more serious defects of the normal

schools as well as their superior features and excellent characteristics. It would be unfair to the normal schools themselves and to those who have contributed so generously to this survey if the writer did not mention these defects of the schools as he sees them. Frankly and briefly, some of the more serious ones are the following:

1. Excellent as the work in hygiene is in many schools, in general there seems to be a failure to realize that health in itself is a supreme good — that the healthful development of children, physical and mental, should take precedence of everything else; that the one great aim of education in the early years, an aim to which everything else should be subordinate and to which everything else must yield, is the development of habits of health, physical and mental. The key to the whole present movement for health education in the schools is to be found in normal-school training; and here in the training and instruction of the school every teacher should be given a clear realization of the great truth put so forcibly many years ago by G. Stanley Hall in the question: "What shall a child give in exchange for his health, or what shall it profit a child if he gain the whole world of knowledge and lose his own health?"

2. The great fundamental defect of all education in this country — the dependence upon instruction and the neglect of training — is naturally found in the normal schools as well as elsewhere. The processes of training are slow and difficult. Instruction, mere talk, is easy and is emphasized everywhere. In all our education we are prone to depend on the easy method of instruction, and we have not time actually to train children. Parents and teachers alike — the better and more intelligent the parent or the teacher, often the worse the fault — do so much for the children that the children have little opportunity to do anything significant for themselves. No responsibility is placed upon them; they are given little chance for initiative and the stimulus of success in their own endeavor. The danger is sometimes the greater and the more subtle with the trained than with the untrained teacher, because the former has learned how to teach, has acquired certain methods, and naturally wishes to exercise that skill. Here is the opportunity for fundamental reform in the

schools; and, if this is to occur, the key to the improvement again is in the normal schools themselves. There is little danger that the young teachers who go out from the normal schools will not do enough in the way of giving instruction. There is great danger that they will do too little in the way of training. Hence in the normal schools the whole emphasis should be on training, and the young teachers should learn concrete ways by which training may be given, and above all should acquire the virtue of self-repression and the spirit of the learner, so that they may repress their tendency to talk, and give opportunity for the children to learn and to do. This opportunity for initiative by the pupil, the opportunity for doing, and the acquisition of habits that come only by training are of fundamental importance to the mental health of the children; and no one is a good teacher who has not acquired the virtues of self-repression and the ability to give training as well as instruction.

3. With the pressure of many subjects, and with the many professional demands upon the normal schools, their limited time, and the defects of preparation in the pupils that come to them, almost inevitably there is a certain lack of pedagogical and hygienic perspective and a tendency to overlook and neglect certain fundamental educational principles in the exigencies of detail in method and grading and concrete instruction.

4. Naturally the normal schools, like all other parts of the educational system, are apt to be unduly bound by convention; subjects are taught because they have been taught, methods are employed because they are traditional, projects and devices are adopted because they are used in other schools. Thus the young candidates go out with a certain conventional professional equipment which has been largely good in the past or may be good to-day in general, but which breaks down in many concrete situations in the schoolroom. What is needed is a better knowledge of elementary psychology and mental hygiene and a better equipment of common sense. This endowment of common sense cannot, of course, be taught, but it is possible to give young teachers a prevision of many pitfalls that will be met in their work and to save them from

making fools of themselves in many practical situations in the classroom.

5. One of the most serious defects likely to be found in normal schools is the failure to emphasize properly the mental and somatic hygiene of the teachers themselves. It seems gratuitous and officious to remind educators that teachers are human, but the need of training in personal hygiene, both physical and mental, is seldom adequately realized, and the personal traits, mental conflicts, and emotional handicaps among these young teachers cannot be properly understood without a knowledge of mental hygiene; one of the greatest needs of the normal schools is to give the teachers themselves the benefit of the fundamental truths of mental hygiene and a training in mental development that will be a safeguard to them in the trying profession for which they are preparing.

The Needs of the Normal Schools

That school hygiene, including mental hygiene, lies at the very heart of the essential preparation of teacher and nurse in the normal school is obvious when one reflects that the primary aim of normal-school training is to develop permanent habits of professional interest. As in any other professional school, little can be done in the way of direct practice; most of the work must be in the development of interests that will, as Herbart long ago pointed out, enable the teacher to profit by experience later in the schools. One of these professional interests is the hygienic interest, a preperception of the things that make for the health of children and of the things that are injurious to health, and the realization that the first thing in the training of normal children is the development of habits of health, physical and mental. Of course another great professional interest is the interest in service; and since so large a part of the service that the teacher renders is in safeguarding normal, healthful development, these two great interests are closely connected.

Special aid would be given teachers by a course in mental hygiene. For example, the great bugbear of most teachers is the maintenance of discipline; teachers again and again maintain that they are not troubled by the work of instruction and the drudgery of teaching, but that the one thing that

worries them is discipline. Strangely enough the modern doctrines of psychology and mental hygiene have not been applied in any systematic way to this important subject. At the present time, with the knowledge we now have, the whole work of the school, and especially the discipline of the school, should be recast and remodeled from the point of view of training and morale; and the fundamental principles of mental hygiene should be at the foundation of such reform. The work of discipline affords excellent opportunity for healthful mental training.

The immediate practical needs of the normal schools in mental hygiene are, then, briefly as follows:

1. The development in all schools of a permanent interest in this subject and the realization of its importance as already shown in the most progressive schools.

2. Emphasis on this subject, to bring about such a permanent interest, by giving a regular course designated as a course in mental hygiene, based on the work in psychology and hygiene, but devoted to the practical applications of these subjects in the development of mental health habits in normal children.

3. Literature on the subject of mental hygiene more distinctly adapted to the needs of normal-school teachers, giving the fundamental principles and teachings of mental hygiene in clear, definite, and practical terms, and avoiding technicalities and overemphasis of the pathological side.

4. Instruction in regard to the pathological side and the testing of intelligence, for the purpose, not of making the teachers capable of clinical work and the diagnosis of various forms of defect, but rather of giving them prevision for the ordinary defects and abnormalities and an intelligent knowledge of what should be done for different cases and what cases should be referred to experts, as well as a sufficient knowledge of this aspect of mental hygiene to save them from the prevalent error of mistaking the results of physical defect, disease, unfortunate education, and the like for real feeblemindedness or abnormality.

5. A pressing need in many schools seems to be that of greater freedom for the normal-school teachers and the removal of the obstacles to giving proper attention to this sub-

ject in the normal-school curriculum; to this end perhaps the development of a permanent interest in mental hygiene in the central authorities.

6. Opportunity for each normal-school student to consult a psychiatrist or psychologist properly trained in practical mental hygiene in regard to problems of study, the development of personal habits of mental health, the avoidance of mental conflicts, and the prevention of those mental handicaps which come from personal individual fears and anxieties.

The method and plan in this subject must be determined for the present largely by local conditions. In some schools mental hygiene is likely to be taught more in connection with psychology, in others more perhaps in connection with hygiene, as this survey shows is the practice in most schools at the present time. It is, of course, more important that the instruction be given by a competent teacher than that it should be given as a separate course or in connection with psychology or hygiene or child study; but where possible a course devoted definitely to this subject is desirable.

Objections

Naturally when the idea prevails in the community that mental hygiene is primarily for those who have no minds, especially for the feebleminded, many teachers do not think of it as concerned especially with the normal. Some of the attitudes shown are the following: that the students are high-school graduates and have studied physiology and naturally hygiene before entering the normal school; that the subject does not concern the particular school in question because only religious subjects, art, or the like are taught; and closely connected with this is the idea that it is a fad and there is no time for it, that the schools have all they can do to turn out good teachers in ordinary school work. But this excuse no longer works in education. Anything whatever can be done in the normal schools to-day; any subject that is necessary can be taught. Our educational standards and ideas of educational value have been so shaken by the war and by conditions since that thoroughgoing changes are possible if they are found necessary. If it is worth while, the best schools seem ready to take the time for it, sacrificing other things

for it, if necessary. Mental hygiene so vitally concerns the most important part of the teacher's preparation and the teacher's work that it is one of the things that should come first, among the essentials; and the question in regard to time should be raised in regard to other things, such as some of the work in methods and the like. Simply let a few schools emphasize hygiene by regular courses in it, and soon other schools will be anxious to follow.

Other objections suggested by the answers of my correspondents and by conditions to-day are that there is no suitable literature, and, again, that a course in this field would be largely an experiment. In answer it should be noted that there is now a large amount of important literature and that the books and articles mentioned in these reports give a good bibliography. The introduction of one regular full course, perhaps of two or three hours a week extending through the entire year, devoted to this subject by itself, would be in nearly all schools an experiment; and yet it would be an experiment in the combination of parts that have been tried in many different schools. Hence it would not be a rash experiment.

The most serious objection to such a course as has been suggested is the fact that often it is hard to get suitable teachers. This difficulty, however, is gradually being met, I fancy; in any case the demand is likely to produce the necessary teachers, and usually any well-trained psychologist can prepare himself for teaching the kind of mental hygiene best suited for the normal schools if he will avoid the more technical work in mental testing and in psychiatry — of which probably a relatively small amount should be given in the normal schools — and devote his time to the conditions of healthful mental development and the hygiene of the fundamental mental processes.

An objection will naturally be raised by some as to the importance of mental hygiene by the query whether children were not quite as sensible and normal before so much was being done for them, before we began worrying about their minds and their mental age. Objections of this kind are apt to be raised; and even educators ask: "Is there anything in mental hygiene for the teacher?"

This reminds one of the old question raised some twenty-five or thirty years ago when the study of child hygiene and school hygiene was begun in earnest in this country: "Were not the children of the older generation, when nobody cared for school hygiene, quite as well off, and did they not develop into more rugged men and women than those of to-day?"

Mr. Marble, the able Superintendent of Schools in Worcester, about that period, suggested at a teachers' meeting that what was needed was not so much an adjustable seat and desk as an adjustable boy. Many sympathized with this attitude; and yet, so far as this was meant or taken as a protest against school hygiene, it had no particular significance and was futile. It did have its significant suggestion, however, as to the need of caring for the mind as well as the body.

To-day, when, at least theoretically, the adjustable seat has won its battle, and when in so many ways we are interfering with the spontaneous activities of children, in directing their play, drilling them in habits of health and the like, it is still more important to recognize the need of developing the adjustable boy and girl. And really the great aim of mental hygiene is that of developing the power of adjustment in children, so that they may face difficult situations and adjust to the concrete situations in which they are placed. There is plenty of opportunity for this, however, without making it necessary for them to adjust to unhygienic conditions in the schoolroom.

Of course in one way it is absurd to ask this question in regard to the value of mental hygiene; for sensible parents and wise men everywhere, from Plato down, have recognized that the health of the soul, habits and attitudes of healthful mental activity, are of supreme importance. Nevertheless, very intelligent people to-day do ask it. At first one is amazed; but what is meant, I suppose, is something like this: Is there in mental hygiene something for the teacher that he does not already know, something over and above what he has learned in society and will learn best of all in the practical work of teaching?

The answer is yes, we do know about a few simple things, and they are tremendously important. They are the things that teachers and nurses and parents are especially liable to forget because they are so simple. And some of these it is

the function of mental hygiene to make emphatic. Even if many of them have been learned as part of good breeding and folk wisdom, they should be made clear and concrete.

Suggestions for a Course

A satisfactory course for normal schools in mental hygiene, at once practical and scientific, must be worked out by extended experiment and study, with the coöperation of teachers and hygienists. Many practical suggestions have already been offered. Others have been made by experts in psychology and hygiene.

The late Dr. James J. Putnam had a strong interest in this problem of mental hygiene in the normal schools, and believed that the best point of departure from which to study the subject, even for a class of teachers, is the practical and personal and social standpoint. Among the problems he would include are the following:

What persons best exemplify high standards of mental hygiene in their behavior?

What nations, communities, or social groups do so?

On the other hand, under what social and personal conditions do unhygienic habits and views of life obtain?

"What relationships exist between abnormalities (so-called) of the unconscious, primitive, elemental tendencies of the mind and the mental health (sense of isolation and inferiority and their a-social and antisocial bearing)? Possibility, nevertheless, of rising above these obstructions and gaining through conscious self-study and careful discipline a new birth of social and religious sort."

Thus Dr. Putnam would begin with the personal experiences of normal-school students and use very largely their own experience of mental conflicts and the like for illustration, and as the basis of much of the instruction and discussion. With this beginning, or whatever other introduction may seem best in a given school, the breadth of the course that should follow is indicated by the results of this survey. And in no subject, perhaps, is it so important to make the work distinctly scientific in its basis and method as in mental hygiene, since so many fads and errors are prevalent in the

community and are often emphasized in the newspapers and popular literature.

Normal-school teachers who wish to formulate a course for immediate use can easily do so from the study of the results of this survey together with the outline of a course suggested by Dr. E. Stanley Abbot in a recent number of MENTAL HYGIENE.[1]

It is especially desirable that the societies for mental hygiene and the normal schools should coöperate in improving the instruction and training in mental hygiene. For a number of years the Massachusetts Society for Mental Hygiene has received requests from teachers and has given them aid in the way of literature, lectures, and the like. Among the more progressive teachers there is a growing demand for help in this field.

The results of this survey are perhaps primarily of most interest and significance for the normal schools themselves; on the other hand important suggestions for the work of the mental-hygiene societies are not far to seek. Most important of all, perhaps, it is clear that if adequate attention is to be given to mental hygiene in the public schools, it must be brought about, not by outside agencies, but by instruction and training in the professional schools themselves.

SUMMARY

After this survey we are in a position to define at least tentatively the term mental hygiene as it is understood to-day by teachers and psychiatrists alike. To put the whole matter in a single sentence, we may say that mental hygiene has to do not only with the care of the mind diseased, but with the prevention of mental disorder and the development of habits of mental health.

Our survey has at least shown something of the scope and the significance of mental hygiene for the teacher.

It has shown what the normal schools are actually doing in this subject, and the literature used.

1 See *Program for Mental Hygiene in the Public Schools.* By E. Stanley Abbot. MENTAL HYGIENE, Vol. IV, pp. 320-330, April, 1920.

It has shown what might well be given in any normal school, and what will be given in good normal schools in a few years.

It has suggested the extent of the course in mental hygiene needed by all teachers.

Naturally a plan like this is apt to be called Utopian. This, however, is in its favor rather than against it. A large part of the things in ordinary school hygiene and child hygiene were Utopian when first advocated. The physical examination of school children, school baths, adjustable furniture, scientific cleanliness twenty-five or thirty years ago were merely the vagaries of scientific theorists. Now they are well-established facts in the best schools. Utopia, as Dr. Richardson used to say, is merely another name for time.

The main points in regard to the aim and significance of mental hygiene in schools for the training of teachers can be summarized briefly as follows:

1. The aim of a course in mental hygiene for teachers should be to develop an interest in the subject, so that teachers may understand the literature and recognize the significance of mental hygiene. Such an interest can be aroused by presenting the facts, and best of all by clinical observation of children, personal training in mental hygiene, and the development of habits of healthful mental activity in the teacher's own life.

2. As a result of the development of an interest in mental hygiene, the teacher should get a knowledge helpful in personal experience and behavior. Such an interest can be developed and such a personal application aided by the study of one's own mental habits, interests and attitudes, and mental conflicts. Instruction in mental hygiene will naturally lead teachers to apply its principles to themselves; and nothing would so improve the personnel of the teaching profession as the development of mental health, enabling the teachers to set an example of poise, of sanity, and of morale in the schools.

3. The general principles of mental hygiene give teachers a prevision for habits of mental health and for mental defects in their children. The difficulty is apt to be that they make snap judgments and sometimes think children that are feeble-

minded are normal, and on the other hand that normal children who have been handicapped in certain ways are feeble-minded. A study of mental hygiene shows teachers the complexity of the whole matter of determining the mental condition of children and the need of referring cases that require diagnosis to competent psychiatrists.

4. A good course in mental hygiene will naturally show teachers the real aim of school training and school discipline — that it is not the correction of individual faults, but rather the development of morale, habits of healthful mental activity, self-control, and the ability to put forth effort and to face difficult situations.

5. A course in mental hygiene will naturally fit teachers to perform their social function in the community the better. Every teacher should be allied with the progressive forces in social evolution, and no one without proper training in habits of healthful mental activity can perform properly these social duties.

6. Again, teachers need extended training in mental hygiene in order to avoid the pitfalls to sound reasoning and sanity of mind that beset all human beings. These are all the sources of error noted so forcibly by Roger Bacon; the idols of the tribe, of the den, and the like, described later by Francis Bacon; and the faults of teachers observed by wise men in the profession ever since that time.

In the teaching profession more than in any other, perhaps, good judgment, sound common sense, balance, self-control, freedom from prejudice, and the scientific attitude of mind are fundamentally important. The importance of this is not limited to scholarship and teaching and reasoning, but really is a matter of significance for hygiene, because only those who have a keen sense of reality, only those who are willing to face reality, and who have acquired the habit of constantly correcting their reasoning by reference to reality, are likely to have that anchor of steadfastness and clearness essential for mental health.

7. Many things are involved in the teaching of hygiene, and it is especially important that the movement for practical hygiene should be furthered. It offers one of the greatest opportunities for social service in modern life. The oppor-

tunity in mental hygiene is as great as in general hygiene. Only by scientific courses in the professional schools can due attention be given to the subject.

Again, to put the whole matter in a single paragraph: The introduction of suitable courses in mental hygiene in the normal schools represents a movement of first-rate importance. Few realize the significance of this subject for teachers. The teacher and school nurse need this training in the first place for their own mental health and efficiency. They need it again in order to recognize those children that are permanently retarded or feebleminded and that should be referred to expert physicians. They need it to do justice to the children handicapped by defect or unfortunate early training. They need it, in fact, in order to do their duty to all the normal children. It is necessary also in order to help the teacher in the problem of discipline and in maintaining the morale of the class. The nurse needs the help of mental hygiene so that she can give the proper advice and encouragement to the mothers who come to her with the pathetic stories of their own children. It is necessary, finally, for the teacher and nurse that they may share in the social service of the community, in all of the many movements for human betterment.

MENTAL HYGIENE AND THE PARASITE

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IT is the purpose of this paper to present an outline study of two types of human nature, the *parasite* and its *host;* to trace the development of these types back to their sources in the mind life of the child as this mind life has been formed and fashioned by the childish reactions to its environment and training; and to offer some constructive suggestions as to how parents and teachers should deal with the child mind in order to prevent the development of these two common types, from which come so serious a percentage of adult failures in adjustment, of adult mental and physical pathological conditions, and hence so large a percentage of social and economic wastes.

For, while mental hygiene and "mental medicine"—or psychological measures taken to correct and remove the psychological causes of pathological conditions—are of inestimable service, once the pathological symptoms have become established or the failures in adjustment have begun to take so serious and evident a form as to demand attention, nevertheless, the most salutary service that mental hygiene has to offer and the most far-reaching results that it is privileged to bring to pass must be in the way of prevention, in the way of discovering and effectively dealing with the psychological pre-conditions and causes of the development of what we later designate as adjustment failures or as pathological conditions, according as the outcome is an actual breakdown in health of mind or health of body or is failure in making personal and social adjustments, failure in finding a happy, contented, and constructive place in the social fabric.

These failures in adjustment, to be intelligently understood, must be traced back in their origin to the way in which the web of life is spun in childhood and infancy. We have too long looked upon them either as growing out of the immediate situation wherein they first manifest themselves in so obvious a form as to demand attention, or else as due to hereditary conditions over which we have no control. The

fact is that, by this attention to the immediate situation and this appeal to hereditary determiners of conduct, we have been prevented from seeing what we can do with the material that nature has furnished us, and from tracing to their sources, in the training of the individual during infancy and childhood, those characteristics of the personality which later cause these failures in adjustment.

In looking into the psychological causes that operate in infancy and early childhood to bring to pass the later delinquencies, failures, and pathological conditions, we need summon to our aid no abstract conceptions of *élan vital,* libido, or any other sort of peculiar psychic entity, by whatsoever name it may suit us to call it. We have only to look to the concrete ways in which the child is made to feel, to think, and to react in the everyday affairs of his childish life, in the common experiences, rather than in the startling or shocking or uncommon incidents, though the latter do in some cases have their part to play. Such experiences are, however, comparatively rare, while the everyday experiences of the child are the real factors that almost universally determine the outcome in later years, and to these we must look for an explanation of the maladjustments and the symptomatic conditions of the adolescent and adult.

Mental hygiene must begin with the very first days of the infant's life, for only as, throughout the years of infancy and early childhood, those precautions are taken and those measures are observed which make for healthy-mindedness in its most fundamental and significant sense will we be able to make any appreciable headway against the ever-increasing crop of adult failures, mediocre attainment, delinquency and irresponsibility, and the various kinds of mental and physical diseases that grow out of psychological conditions and causes. Nor need we be baffled by any sort of abstract idea about what constitutes the essentials of an environment that makes for mental health. The orderly, obedient, controlled, well-poised nature—the nature that is able to face reality with upstanding courage instead of turning from reality to live a life of phantasy, the nature that does not shrink from the world of facts with timidity and a craving for a soft place and a pleasant berth, that is able to take criticism and direction, that

controls feeling by intelligence, standing foursquare to every wind that blows—this sort of nature must be provided for in the infant days, and its foundations laid by the very atmosphere that surrounds the child. And this atmosphere is no subtle, indefinable, and vague abstraction; it is the sum total of the habits of ongoing in the hourly care of and association with the child, in the manner of his being handled and dressed and fed and bathed, in the attitudes of his elders in every matter that may come up in his presence, in their moods as they are about him, in their own ways of meeting every incident in life, be it great or small. Too much emphasis cannot be laid upon the fact that it is out of the commonplace, everyday, matter-of-fact experiences of the child that come the various characteristics that form his personality and that determine the nature of its expression in later years. The world of parents and teachers needs to learn this lesson above all others—that nothing dare be considered of no moment in the life of the child merely because to the adult it is of no special interest or importance, or merely because it is the experience of a child and therefore cannot be of any great significance. We must never forget that it is from *his own* reactions to *his own* experiences that he is getting his bent; out of the myriad small happenings of his daily life is being formed that great dynamic source of motivation, the unconscious, which will ever wield so powerful an influence throughout his later life for good or for ill in determining his choices, tastes, judgments, and reactions. Moreover, the adult needs to keep this fact ever before him—that the child is having his nature formed for the most part without any understanding, in the adult sense of the term, of what is so forming it. Great harm is frequently done through failure to realize that for a child to be molded and fashioned by a given experience or situation, it is not necessary for him to have any rational, clearly conscious, and definitely ideational understanding or conception of any of the elements in the situation to which he is reacting. Neither can adults be the arbiters as to just what aspects or phases or elements of a given situation the childish nature is going to react to, or will be bent on absorbing.

How often, for example, do parents permit a small child to be present when gossip is being whispered, or when grave

affairs are being discussed or affairs that are decidedly not for childish ears, under the mistaken impression that, because the child cannot understand the meanings, intellectually, of the words and situations, of the circumstances and the events, these are therefore passing entirely over his head and hence that he is not being affected thereby. Childish nervous systems are more bundles of feeling-response machinery than of idea-response machinery. The sneer, the jeer, the solemnity, the anxiety, the indifference, the insincerity do not have to be understood as such, nor their causes, real or imagined, grasped by the child, in order to take effect in him, any more than it is needful for him to understand the nature of the physical calamity that would befall him, or the nature of the physical force that would produce the calamity, should lightning strike him, in order to have fear of lightning engendered in him. All that is needed is that the attitude of fear when the lightning flashes shall be taken in his presence by others, and he has been helped by that much one full step toward the same sort of fear reaction himself in response to the sensory stimulus of the lightning flash. Let a person be treated never so politely in words, but with a lack of sincerity, the presence of positive, though highly-cultured frigidity, before the child, and the seeds of hostility and dislike have been sowed in the child's nature toward this person, for his reactions are to the feeling attitudes expressed, rather than to the words that belie the attitude. Let the attitude of parents and adult members of the family toward their daily occupations at home or in office be that of dread, or boredom, of dislike or contempt, let real joy and spontaneity of manner and lightness of heart appear only when the holiday, the rest hour, the game, or the diversion are being spoken of or experienced, and the child begins the formation in his nature of attitudes toward work that must be utterly eradicated later if he is ever to find himself in his work as an adult, if he is ever to make his work, whatsoever it may happen to be, that in which his nature finds nourishment and contentment and satisfying expression. And when mother or father finds the growing boy or girl avoiding work, hating to do the errands and take any of the small responsibilities about the home, they are all too prone to lay this to "natural" laziness in human nature, instead of realiz-

ing that they are reaping what they in large measure unwittingly sowed in his nature by their own daily feeling reactions to their duties and occupations, their cares and responsibilities. Healthy-mindedness toward work and toward responsibility must be engendered and fostered in the child's nature in exactly the same way in which reverence and courtesy are engendered and fostered—namely, by the attitudes of the adults who have the child in their charge.

As a further illustration of the fact that children develop unhealthy attitudes of mind in the earliest years, and long before they have any intellectual comprehension of the situations to which they are reacting, the writer would cite the case of a little boy of six, with whom corrective work has recently been done. The little fellow, by the time he was four years of age, had become completely unmanageable. Much of the difficulty was caused by this very course of procedure—of trusting to the notion that because the child could not understand, intellectually, what was being said or what was going on in his presence, he was therefore not being affected by it. And as he came to be old enough to be able to understand, he had already formed such deep-seated and injurious habits of response that the parents were unable to do anything with him. Not only had they foolishly permitted themselves to discuss whatever they pleased in his presence, but he had been allowed from the time he could walk to toddle to answer the doorbell with his mother, and to be about, listening, whenever father or mother would be talking with callers on no matter what errand, instead of being taught to keep on about his play, attend to his own little affairs, and keep his distance. Undoubtedly he was too young, at the first or even later, to understand what was being said, at least as the adult understands it. But he was not too little to be absorbing emotional attitudes, nor was he too little to be forming the habit of not minding his own affairs whenever there was a conference going on between adults. He was not too little to be having his curiosity stimulated and fed until he had become a sophisticated little eavesdropper. When he was questioned about it—as to why it was he always stood around listening to things that were none of his affairs—he in his childish way made it clear that it was not because he understood very well

what was being talked about that he found these conferences interesting, but it was the emotional satisfaction he got out of the attitudes and moods and the general air of "something important going on." He had become a regular little "Paul Pry," and at six years of age would sneak up or slip about anywhere only so that he might be near when adults were talking, enjoying what ideas he could understand and getting immense satisfaction out of the purely feeling side of the situation. So deeply has this sort of response been built into him that after a year of the most arduous and continuous labor with him, though great progress has been made, the boy still needs the greatest care and watchfulness in this regard, before he shall have had this most unhygienic insatiable curiosity corrected in him; a curiosity that, both in its nature and in the form of its expression, will inevitably, unless permanently eradicated, lead him to serious failures in adjustment later and to many a sad and painful experience.

It is of course true that modes of procedure which would form serious habits with one child might not have serious effects upon another, just as methods of training that will succeed with one may not be at all suited to another. The psychology of individual differences that has received so much emphasis during the past twenty years has brought to light the existence of great variations between individuals, as regards their intelligence chiefly. This study of differences in individual intelligence has brought to pass a most timely movement toward suiting our method and content in education more nearly to the intellectual characteristics of the individual child. It needs to be emphasized that even more subtle and significant differences are to be found in the emotional natures of children, and upon these differences in the emotional constitution must rest the differences in modes of procedure in mental hygiene; that is, the training of children must be suited, not only to differences in intelligence, but also, even more, to differences in the modes of emotional response, the tendencies to emotional expression, peculiar to each individual child, if healthy-mindedness is to be developed.

There are, of course, general rules of procedure that make for the best hygienic conditions surrounding the child, but it must ever be borne in mind that no cut-and-dried, rigid

methods of procedure can be indifferently applied to each and every child. The concrete way in which a principle of training is to be applied must always be determined by a study of the characteristics of the child who is being trained. One of the commonest of unintelligent remarks that one hears from distracted parents is: "I cannot understand why this child should behave as he does, as I have given him exactly the same training and treatment as the others." And frequently right in that very fact lies the reason for the child's failure to be what the parent has fondly tried to make him by methods that were unsuited to his particular type of nature.

Again, when it is found that bad habits have been formed and that undesirable tendencies are finding expression, another convenient and often used defense by which parents blind themselves to the actual facts and seek an excuse for failing to study and deal with the child according to its own peculiar needs is to appeal to the well-worn phrase: "Oh, just give him time and he'll outgrow it. All children have to go through this sort of thing. He'll come out all right in the end." The support for this destructive and paralyzing creed is found in three all-too-common fallacies. First, there is the very common fallacy of noting only the positive instances in which children either actually or apparently do "outgrow" their bad habits, and failing to note the more numerous negative instances in which they do not. Second, there is the error of supposing that "time" or some other unanalyzable force or cause is that which works changes in individual character and can be counted upon to bring the desired characteristics forth in the personality if only we will have the patience to let it, though doing nothing concrete ourselves to mold and fashion the child nature. If the changes actually do take place, they are the results of the child's having met with concrete experiences that have put a stop to the harmful habits and the injurious attitudes of mind before they have become so ingrained as to be unalterable without the special technique of the analyst. But far more frequently there is the third fallacy—that of taking the superficial appearance for reality, in that the changes seen are purely specious, the inner motivation having changed not at all. It is only that the form of expression has changed in such a way as to hide its source

and conceal its true nature. Many a child, for example, has "outgrown" flagrant and open deceit and petty pilfering only to practice the more subtle forms of deceit upon his associates and to follow "honesty" as the "best policy." In such cases there is no genuine honesty of nature being expressed, but only the deepest sort of dishonesty of nature finding outlet in every form of rationalization, every sort of casuistry, every sort of subtle excusing and defending of wrongdoing, which ever keeps within the law, ever uses good manners and acceptable social customs for realizing the satisfactions of a nature that is at bottom thoroughly unsocial, thoroughly self-centered, concealing itself under this mask of pretense of the genuine.

While, then, we recognize that there are natures that may be subjected to wholly undesirable childhood experiences with perhaps a negligible amount of harm being done them, and that there are others that, by reason of later experiences, actually do cast off undesirable characteristics and take on desirable habits and attitudes of mind, nevertheless, these natures can by no means be used to prove the fallacious rule that "the child will outgrow it." There are very strong probabilities against any such "outgrowing," and what is taken for outgrowing is far more frequently an ingrowing in which the results of the experiences have sunk deeply into the unconscious, there to function in so thoroughly rationalized a manner as to be hidden as to their source and nature both from the individual himself, as he comes to maturity, and from all but the keenest students of the back-lying causes of human behavior.

There is special need, then, that we make a study of the nature of the individual child, to the end that his training may be suited to the characteristics that are peculiar to him, at the same time that we hold fast to the application of methods and principles that must never be violated with regard to any child. For example, it is true in general that children need to be fondled and petted and "loved." But there is most serious need to study each child from the angle of the psychological effect upon it of parental petting, cuddling, and fondling. These purely physiological expressions of parental affection should be wholly governed by consideration

for the child's welfare rather than by the blind impulse to satisfy the parents' instinctive desire to fondle and hover over their offspring. Just how much of this petting and fondling is good for the child depends in part upon the child's own individual nature and upon the manner of response produced in him by these expressions of affection and tenderness, and in part upon the attitude of the parent who is handling the child; for often such petting and fondling as a child should rightfully receive is rendered unwholesome for it by the attitude of the adult who is doing it. The child is ill, for example, and must needs be taken up and held to rest it from long hours in its bed and to give it tender comfort. If this is done by the parent in an attitude of fear and nervous anxiety for the child, instead of with healthy and wholesome quietness, with confidence and assurance of manner, then a positive injury is done thereby to the child, because of the reactions upon it of this attitude of anxiety and fear. Physicians are all too well acquainted with the fact that the parent is often quite the wrong person to handle the sick child just because of this thing, and a child in a serious condition often begins to recover only when the frightened and anxious parent is persuaded to leave these tender ministrations to the cool, confident, well-poised nurse. In the case of a serious illness it is easy to see this principle. But it holds good at all times that whether or not the fondling and petting so dear to child and to parent is wholesome for the child will depend in large measure upon the attitude of the parent, as well as upon the nature of the child.

There are children in whom these natural instinctive expressions of parental affection develop a harmful appetite for coddling and prevent the development of a sturdy and healthful independence. This prepares the way for the nature of such a child to turn away from reality as he comes to adult years and constantly to seek for palliation, for sops to the feelings, for soft and pleasant treatment at any price. Such a procedure thus starts the child well on his way towards becoming the host for parasites in later years. In children of still different natures there may be developed by apparently innocent and natural petting and fondling a harmful sex consciousness or harmful "infantile fixations," and, finally,

injurious sex perversions. And we may by no means assert that because some children apparently survive indiscriminate and uncontrolled fondling, without obvious catastrophe, they therefore have had no real damage done them thereby, for the results may show themselves, and often do show themselves, in devious and hidden ways in the motivation of the individual in his adult years.

There are children who, because of their natural reactions out of hereditary tendencies, call forth from the parents just the sort of treatment that will be their ruin. Too often do we see a fond parent, because of the natural brightness and strong initiative of the child, pushing him on to an overuse of his energies, stimulating him to "show off," developing thereby in the child just those forms of self-projection that will cause his undoing in later years. The child is eager to be seen and heard and shows increasing evidence of ability to do things beyond his years, and the parent, who in turn desires to be seen and heard through the credit and attention that so bright a child will bring him, urges him on. Where only the most insistent care and effort will suffice to prevent one child from overdoing and coming to fatigue, as well as to a blasé attitude of mind, through experiences flooded upon him beyond his capacity to make healthful adjustments to them, in another child only the most persistent care in the very opposite direction will prevent it from becoming idle and shiftless, a useless and destructive parasite upon some unfortunate individual and upon society throughout the days of its life. Over and over again do we see this untoward situation of the child calling forth from the parent the very opposite type of reaction from that which it should receive. The active child tends to call forth overstimulating treatment from the parent. On the other hand, the lethargic, inactive child, who lops and leans and wants always to be held or to sit about, who constantly seeks to get parents to do things for it instead of seeking to do them for itself, tends to call forth from the parent treatment that fixes this sort of reaction in his nature. The parent all too often with such a child responds to its inactivity by making a toy of it, by constantly remarking in its presence, as if this were something to be proud of, that it is lazy and inactive and always making the

parent do things for it that it should do for itself, and suiting the action to the word by giving in to the child's teasing instead of stimulating it to be active and to do for itself. By this form of procedure, the nature that needs to be denied coddling, that needs to be encouraged in every way to make effort if the necessary inhibitions and habits are to be established that will prevent the child from becoming a parasite, is helped, instead, to bud and flower and grow after its kind, according to its hereditary bent. Specific study of just such a nature, in its beginnings and its adult outcome, is presented later in these pages.

Thus, through lack of understanding of the child nature, through failure to realize how serious are the results in the characteristics of the personality that are being developed and fostered by their manner of dealing with the child, and through lack of understanding and controlling of their own tendencies to instinctive emotional response to the child, parents and adults who have any dealings with it start the parasite well on its way before school age has been reached.

The term parasite is used here to designate a particular type of nature, rather than to cover all those persons who may be failing to make their proper contribution to social values, who are more or less being carried along by society without themselves rendering adequate return for value received. These latter, while parasitic in many ways in so far as failure to produce or to contribute is concerned, differ from the parasite proper in this, that this failure to make contribution is not due to the development of inherent parasite qualities, but to the fact that such persons have not learned the way of life of the contributor to social values. There has been a misdirection or perversion of qualities, which, had society and environment furnished the right sort of training and opportunity and incentive, would have been directed into truly constructive channels. The qualities that would make them producers are there, and when they are thrown upon their own resources or placed where there is appeal to these qualities and where responsibility comes to rest upon them, they at once make some response, begin to make some effort, seek to make some return and some contribution. Under the same circumstances, the genuine parasite seeks by every means to

avoid responsibility, runs to cover, throws the burden upon others, makes appearance of being willing to carry the responsibility or engage in the work, but always does whatever it does in such a way that it gets excused, having succeeded in duping its host into believing it physically unable to do the work, or else makes a great show of really doing the work, but always by subtle craft does it in such a way as to make it necessary for some one else to come in and carry the responsibility, lift the load, do the work. Who has not seen the beginning of this sort of thing with some child who, when asked by the parent to perform some simple household task, would so slight and bungle it that the tired or impatient, and certainly unwise, parent, goaded by the necessity of having the thing done right or by the wastefulness of the outcome if it is left to the child's bungling, dismisses the child with the declaration that she will do the work herself rather than see things spoiled, or even excuses the child with playful remarks on its awkwardness or mollifying comments on its inadequate strength? With children of a certain nature, this is the first step toward performing things that they want to get out of in such a way that some one else will be forced thereby into helping them or into doing the things for them. Then, as soon as the parasitic child has learned, too, that a show of willingness and a pretense of doing the very best it can will get it excused from work and at the same time get it credited as highly as if it had actually done the work, it has been provided with one of the chief methods of procedure whereby the parasite seeks to get itself accepted, to thrust responsibility upon others and at the same time to get credit for "doing all it is able to do."

The parasite always works by this method of sham and pretense and false promises, ever putting up a profession of willingness to make contributions, but never carrying this profession out in reality; ever taking all it can secure of support, position, credit and admiration, adulation and praise, and giving nothing but empty husks to its dupe or host in return. The parasite ever seeks to get itself accepted and to be in favor by making the appearance of following the rules and conventions and chiming in with the tastes of the set or circle of society in which it happens to be moving, ever putting up the pretense of coöperation, of agreement, of willingness

to oblige, and ever offering some sort of plausible excuse for its failure to show concrete results.

The host or dupe of the parasite is always one of those unfortunate individuals who by training has not been taught how to face reality, how to distinguish the spurious from the genuine, and whose tendencies in this regard are due primarily to the way in which his emotional nature has been improperly organized and directed in the growing years. These characteristics have their inherent basis, it is true, but they have been formed and fashioned into motivating complexes by the way in which the child has been taught to react to his everyday experiences, particularly in the infant and pre-school years.

The child who is most easily shunted off from facing reality, who is most likely to be given such a bent as to cause him to be deceived and allured by the specious attractions and offerings of the parasitic nature, is usually one of strong and unstable emotional nature. He is a child of unusual capacity and sensitiveness of feeling, which, if properly understood and directed and made use of, would furnish splendid driving power for constructive, courageous, upstanding procedure throughout his life. But unless this deep and sensitive feeling life of his is understood, it may come to generate the deepest sort of rebellion against control and direction and to develop a subtle sense of personal injustice, and to move the individual ever to turn away from those who seek to save him from himself, who seek to teach him robustness and honesty and straightforwardness and self-control, and turn him toward those who make their specious and destructive offers of sympathy, of softness, of understanding, or who appeal to his various appetites, holding out promise of satisfactions which he has failed to receive in other directions. The beginning of this sort of thing is all too frequently in the earliest infant months, in which there is constant response by one parent or the other to outbursts of infant crying and infant temper, a constant attempt to pacify, to quiet by whatever means suggest themselves, particularly by offering food or something to hold in the mouth, and by unrestrained and unwise petting and attention, all accompanied by a weak sentimentality of feeling instead of by firm, quiet, healthy attitudes

of mind that would tend to accustom the child to something besides a complete pandering to his emotional explosions. The youngest infant quickly has its nervous system and its feeling life organized and differentiated by this sort of thing into a tendency to be rebellious against any control, into a tendency to seek through "tantrums" the satisfactions of its physical wants.

A child must have warmth and strength and loving, tender care; a child must have brooding and petting and all healthy and healthful show of affection from those who are caring for it. But parents need very much to learn the difference between genuine, healthful, and helpful sympathy and tenderness and the destructive, unintelligent sort so often displayed. True mother love and true tenderness are not the mere instinctive expression and satisfaction of feelings aroused in the mother by the infant's plaints, but these feelings guided entirely by an intelligent understanding of what is best for the little life, both at the time and in its future development. To run and pick up the baby and offer food and coddling in response to its every complaint may be of intense momentary satisfaction to the ignorant and overindulgent parent, but it is very harmful to the best interests of any child, and results later in untold suffering for both child and parent and for all those interested in the child's welfare. Such treatment brings forth its inevitable fruit in the growing loss of control of the child, in the delinquencies that come through his later inability to control or understand himself or to take any vigorous and straightforward criticism and direction, and in his tendency, in every situation where his feelings are aroused and hurt, to be unable to control them, unwilling to get hold of himself, but ever eager to turn to whatever offers his feelings the coddling or the satisfactions similar to those he became accustomed to in what seemed to the parents to be the perfectly proper and harmless—yes, even necessary and helpful, natural and praiseworthy—expressions of parental feeling and parental tenderness for him.

A still more injurious situation develops in those all too frequent instances of disagreement between the parents or the adults who have the care of the child. When mother sees that baby must not be fed because it has awakened too soon

and that this great outcry of his must not be responded to, but must be made to abate by a firm, gentle, and insistent refusal to mollify or pacify, that the regular order of feeding must be ahered to, then father or grandmother or aunty or neighbor comes in with just the very show of sympathy which acts as a balm to little wounded feelings and as a rebuke or an opposition to the procedure of the mother. And thereafter baby knows that mother is the person from whom he cannot get satisfactions, while father or grandmother or aunty or neighbor can be depended upon to humor him, and to them he turns, away from the very sort of treatment that will save him from being spoiled and finally from becoming, in later adult life, the prey of any one who comes in when he is seeking to get his own way, to avoid control or direction, looking for sympathy instead of facing his facts and dealing with them. Thus is formed the habit in the nature of ever seeking a solace to the feelings, ever seeking the company of those who offer satisfaction to appetite, to pride, to desire for softness and pleasantness, and no tendencies are formed in the nature to find satisfaction and comfort and companionship with those healthy natures who would give honest criticism, who demand a strict accounting, who are direct and straightforward and frank and courageous and thus genuinely and truly kind. The pampering and misdirection and perversions of the feelings begin with the infant. If indulged by the parents, then, when the child meets with those who will not allow him to have his own wilful way, he turns from them to his parents for sympathy and support, and gets it. He will not face the criticisms and rebukes, the insistence upon obedience, of his teachers, but brings home tales of being abused or treated unfairly, and the fond and foolish parents take his part and continue to fasten upon him this habit of turning away from facing the actual facts of his conduct, from forming habits of life that will stand him in good stead in the face of the world of real things which he must meet. And then they wonder why he has chosen a weak, unstable, parasitic companion for life when they later find him married to a woman who will make no effort to carry any responsibility, who has nothing in her that any healthy-minded person should desire her, but who always keeps up the appearance of soft and winsome

ways, and is plainly robbing their son of his very life while he is in the act of turning to her for the softness, coddling and the sop to his feelings which he has come to demand as the result of his misguided childhood training.

The persistent and united campaign of parents ever to prevent the child from facing his little problems with honest courage and sturdy, straightforward acceptance of the consequences of his mistakes or accidents or misbehavior, by always offering him sops for his feelings, always excusing his failures instead of encouraging him to acknowledge and correct his faults and take heed from what he has suffered to avoid similar things in the future—this sort of procedure, while common, is not perhaps as common as the situation in which, after discipline is meted out, the child finds some softness or palliation in his offense in some other adult member of the family or in some friend or neighbor who, instead of helping him by no show of false sympathy, takes his part, either openly or covertly in the numerous ways in which it is possible to get it across to the child that mother or father or teacher has been just a little hard on him. The child is thereby prevented from accepting his treatment as just and right, and feelings of rebellion and resistance are fostered in him toward the correction that was attempted. And in very frequent instances the parent or teacher, after having administered some corrective discipline, ruins the entire result of this by taking some palliative measure thereafter, making the child feel that she agrees with him in considering the treatment harsh or unjust and that she is "taking back" what she has done or said by way of correction.

Too much attention cannot be paid to seeing to it that, in all matters where the child's will has to be crossed, his desires given wholesome direction, or some corrective measure taken, he does not develop and retain a feeling of rebellion, but that he comes to accept the situation as just, to acquiesce therein, and to go on happily and contently. It is often in the mistaken measures taken to get this feeling of rebellion or injustice out of the child that the harm is done. The measures taken are palliative, or are given as a sop, instead of being directed toward establishing confidence in the person who has given the correction and toward developing a contented

acceptance of the justice of the procedure. Care must be taken in discharging the feelings of rebellion and injustice that the measures used are in no sense palliative, in no sense given or received as a sop to the feelings. It is not enough that the child merely stops feeling rebellious, angry, injured, or ill-used, when he is corrected, directed, or has his will crossed. These feelings must be replaced by a sense of the justice and fairness of what has been required of him, by a sense of confidence in the act and in the intentions of the persons who may be dealing with him; and, if old enough to have such understanding, he must be given some notion of the fact that the course being pursued is good for him, whereas the one he might have been pursuing or might have wished to pursue would be harmful. In so far as this change of feeling takes place and some understanding of the value to him of what is being done is developed in him, he *accepts* in the deepest and most significant and healthful way the direction and correction. For now what has been done has received the support of his feeling life, instead of its opposition, and without this support, any sort of intellectual understanding of the rightness and value of the course pursued is of negligible value. Unless such fundamental acceptance in the feeling life is brought about with the child, then the rebellion that has merely quieted down for a time because of some other reason will inevitably flare out again at the next incident in which his will is crossed or his desires opposed, or else will turn into some form of deceitful and hypocritical attitude of outward acceptance, simply biding its time to work in less obvious and less explosive ways against any sincere obedience to those who seek to mold and train and educate. When the outward expressions of rebellious feelings, or the feelings themselves, are merely allayed through some sort of propitiation or palliation, or through punishment, without there having been developed any genuine acceptance in the emotional life of the situation that has aroused the rebellion, then there has not been any real growth in obedience brought about, but only repression or momentary truce. Genuine obedience is a matter of inner attitude and not of outward performance alone.

How this discharge of rebellious feelings is to be secured, and just how to engender the opposite feelings of willing and contented acceptance of direction and control, cannot be written down as a rigid and exact formula or prescription. The methods used must depend in part upon the age and the individual characteristics of the child that is being trained. But no matter what is said or done—however well, in itself, it may be suited to the degree of understanding that the child has and to the nature of the particular situation—it will be of no avail if accompanied by the wrong spirit or attitude on the part of the one who is dealing with the child. It is the spirit and attitude of those who deal with the child that are of the most vital importance. In the very young child, the whole response is to the emotional elements in the situation rather than to the ideational content of what is said. But it is true also, throughout life, that it is not so much what we say as how we say it that brings reactions from others, both children and adults. The attitude of sincerity, of fairness and justice, of patience and genuine regard, of confident and quiet, kindly authority are absolutely indispensable in securing the contented acquiescence of any child in matters of discipline, criticism, correction, and control. In the very young child there may be little or no understanding of what is said, but there is no lack of sensitive response to the emotional tone present. In the older child there may be very good understanding of what is said, but this is not and cannot be accepted by him so long as there remains any emotional resistance in him, and so long as there is lacking in the adult the emotional attitudes mentioned above.

When the child, on being fairly and justly dealt with in correction and criticism by parent, teacher, or companion, does not accept the treatment as fair, but has generated within him feelings of rebellion and injustice, he is in exactly the right state of mind to be misled by that person, be he playmate or parent, friend or stranger, who offers the pat of condolence, the false sympathy, the soft word, and, perhaps, in addition, some tidbit to eat or some show of special favor, thus adding to the solace of wounded and rebellious feelings the satisfaction of appetite. And because of this feeling of rebellion and injustice, the child is helpless to refuse the

proferred sweetmeat or favor or sympathy, even though he may know that he ought to do so, just because it accords with his own deep hunger for approval, his desire to receive credit and have sympathy, even though it be not rightly earned. Through such incidents as these there is built into him that tendency that through all his life will make it hard and sometimes impossible for him to face reality where it touches his emotional life. Upon such a person the human parasite always seeks to fasten itself by offering the appearance of real satisfaction, by appealing to his appetites, by show of apparent sympathy with and understanding of the tender feelings of its misguided host. And her host sells himself out for the husks she has to offer because of his undisciplined emotions, his inability to discriminate between the false and the true, his lack of courage, his desire to have this fictitious peace and quietness, never having experienced the satisfactions that come from facing and dealing with reality in a robust and straightforward manner, never having acquired such control over his appetites and feelings as to be proof against being enslaved to her through them.

That the parasite type and its host may stand out more clearly, the following outline sketches are presented:

Study I

This study is of a married woman of about forty, in good health, who had had good educational advantages and whose husband occupied a position of prominence in his profession.

At forty years of age, by her abject selfishness, her hatred for work, her unwillingness to carry any responsibility as wife, homemaker, and mother, and by her constant process of parasiting upon her husband, taking everything and giving nothing in return, this woman had brought her husband to a condition of serious ill health because of his grief, anxiety, and despair over her failure. He was hopelessly despondent about himself, his affairs, and his young children, who were in a serious condition morally and physically through the mother's neglect and her constant active opposition to any attempts made by the father to give them the necessary moral training.

Her method of procedure from childhood had always been to make an appearance of being busy or of being willing to be busy and of carrying responsibility, and yet always to have some one else actually do the work or carry the responsibility, while she got the credit; or else she would contrive to get excused from doing anything on grounds that still left her on a pedestal of approval with those with whom she wished to stand well that she might gain something from them. As a child she had learned that by tantrums, feigning delicate health, inducing fainting spells, etc., she could at any time avoid obedience and get excused from doing anything to help her mother. As she grew older, she used the plea of delicate health to avoid taking a responsible part in any matter of a social sort that savored at all of work. Furthermore, the father greatly contributed to this state of affairs in that he opposed any attempt on the part of her mother to correct her, offering such pleas as that she was not "really very strong," that she was "sensitive and highstrung," and that she was really such a good girl in every way that she should be favored. Thus the girl played the father off against the mother to get her own way and to keep up her life of disobedience and shirking. The training of this parasite actually began in infancy, by the opposition of the father to any sort of direct, persistent, systematic, orderly treatment of the child, to whose every cry he was insistent that immediate attention be given, so that while still in the cradle she learned to have tantrums to secure attention and get what she wanted. This was followed on the part of the father by every sort of foolish attention and coddling and adulation as she grew older, and before she was six years old she had learned just how to avoid any obedience, how to avoid taking any direction or submitting to any restriction through show of ill health, through having a "nervous spell," and finally, in early girlhood, by inducing fainting spells at will. She had also through her girlhood learned how to get herself in with people by a great show of willingness to oblige, and by a false show of delicate tastes, a false show of modesty, of daintiness of manner and the like, so that before she was adolescent she had the complete stock in trade of a parasite. Her way was always to get what she wanted out of people through the use

of her trickery and then to turn on them in some way and discredit them with others, selling them out in every subtle way she could, though always seeking to do this in such a way as to protect herself. No one who ever befriended her but was turned upon in this cruel fashion as soon as she could get the favor she wanted in some other direction. Moreover, as soon as her machinations had secured her a place with any one, as soon as any one showed any interest in her or any dependency upon her, then she ceased to make effort and settled down to be the recipient of all the favors, giving nothing in return, but always on the lookout to strengthen herself in some other direction. She would never work for or make any effort for or any return to those who cared for her, those upon whom she could in any way trade because of their relationship to her, of their interest in her or dependence upon her. Yet she never ceased to try to make it appear to them and to others that she was making all the effort she could, that she really could not be expected to do more on account of her frail health or her sensitive disposition; or else, by cruel tantrums or storm of tears and show of being greatly abused, she tried to get them to remove the responsibility from her, to take back any sort of blame they might have put upon her and to cease exerting any pressure upon her to make effort.

This harshness and cruelty she would never show openly to any but those who she felt would condone such conduct in her, or over whom she felt she had sufficient power to be able to throw off her mask of pretense of humility and gentle willingness and force them by her tantrums into doing her the service she desired. The significant thing to note here is that the mask of assumed gentility, humility, soft and ingratiating willingness, sweet docility, of eagerness to render any service and show of sympathy, never made her any friends among discerning, healthy-minded people, never deceived any but those who were ready to be deceived thereby. For the parasite has little chance to fasten itself upon any one except the person who by nature and training has been prepared to become her dupe, her victim, her host. No one who has learned to face reality, who is not looking for false sympathy, who is not blinded by his own feelings, is ever deceived long

enough by such a person to permit her to become fastened upon him. And yet a man of splendid intellectual qualities, of unusually good preparation for one of the highest and most difficult of professions, was in her net. He had found out, very soon after his marriage to her, that he had married a sham, but in his false pride and false sense of duty he had set to work to cover her up, to conceal in every way the fatal mistake he had made, and to try to make his ideal come true in her through giving himself unreservedly to her in the most loyal way. And the more he gave, the more she took and the less she returned to him in any conceivable way, until at last she had almost destroyed him. How could it be that she should ever have deceived him so that he would turn to her as the one to be his life mate?

The answer is to be found in the inherent nature of the man and the way in which this nature had been molded and fashioned by his childhood's environment and training. A child of unusually sensitive nature, great emotional capacity, and fine intelligence, he had been protected by his too indulgent mother and sisters against facing reality in the shape of control and discipline and correction by his father. They did not understand that by this method of treatment they were forming in him a nature that would ever turn away from those who would meet him and deal with him in an upstanding way and give him honest and healthful criticism—a nature that would turn toward those who would offer a specious protection to his feelings, which had never been trained to robustness and firmness and stability. It was this show of softness and sympathetic understanding, of docility and false tenderness, of helplessness and delicacy of manner and nature that attracted him to this girl and made him her dupe, and brought him and his children to ruin after years of wasted life and misspent effort.

Study II

This is a study of a young man of about thirty, of good family, well educated, and possessed of admirable qualities had these been given constructive and healthful direction. This young man found himself on the verge of ruin through having become infatuated with and finally married to a

woman who was a typical parasite. She was, furthermore, far beneath him in birth, education and intelligence.

She was able to fasten herself upon him because of certain qualities in the organization of his emotional life which betrayed him into this serious situation.

This study is of great value in that it shows how, out of the failure to understand and direct the emotional life of the child, there come those forms of motivation which bring the youth and the adult to later disaster. Such wreckage not only robs the unfortunate victim of the realization of any sort of desirable and worthy life for himself, but, through him, brings sorrow and loss to others and loss to society because of his failure to come to any development that would turn his abilities into constructive and productive channels, making him a distinct social asset instead of a social loss.

He was the youngest of a large family, being many years younger than his next older brother. Throughout his childhood, his older brothers and sisters had the chief care of him, his mother being in delicate health and well on into middle life when he was born. As a child he did not receive the coddling and nursing that he craved, and through this he developed a deep sense of injustice as well as through the fact that he never could understand why he was not given the same treatment as other young children, cousins and neighbors. Because he was of delicate health, a different régime had to be prescribed for him from that which he saw other children enjoying; for example, his play and rest hours had to be carefully regulated, where more robust children were being allowed greater privileges, and when sweets were passed about amongst cousins and acquaintances, he was not permitted to indulge in them. In these apparently trivial matters, and in the host of other measures taken to protect and care for him according to his physical needs, lay the secret of the development of intense rebellion against his family, of a deep feeling of being unjustly and unfairly treated. So early did this show itself that at four years of age he refused with great show of childish bitterness some presents that were offered to him, saying that it was no use to accept them for they would just be taken away from him. From a careful study of the facts, it appears that everything

was being done for him in the spirit of greatest kindness, out of real concern for his best good, but that because those in charge of him failed to understand the causes of the resistance that he set up, failed to secure his contented acceptance of the things that were being done for his good, failed to secure his confidence and his affection, there were formed in him great emotional repressions and deep dissatisfactions which, as he came to his adolescent years, were prominent factors in turning him to seek outlet for his pent-up emotional life in sex perversions. Adolescent sex perversions and uncontrol can be traced back in a large percentage of instances to repressions and resistances developed in the emotional life in the pre-adolescent years. There is no greater protection for the adolescent against the formation of destructive sex habits than a happy, contented ongoing in the pre-adolescent childish years, during which he learns to take direction and to exercise control over his childish appetites and desires without repression, rebellion, or resistance.

In turning to this girl in his young manhood for satisfaction, he was motivated at the first by purely sex attractions. But she quickly intrigued him by making a great pretense of understanding him, of being sorry for him because of the ill-treatment which he felt he was receiving from his family. And in her turn she made appeal to him by relating how she, too, was in such a plight because ill-used and betrayed by others, and she made protestations that he was kind and fair and just to her and treated her with a consideration that others had never shown her. In his state of mind he was ready at once to be the chivalrous knight and come to the aid of any one who, like himself apparently, was suffering from gross injustice and particularly of one who was offering him just that sop to his feelings and making that appeal to his appetites which he craved. Blinded thus by his own sense of injustice, going to her in his repression and unhappiness and finding specious relief and specious sympathy and understanding, he was persuaded by her to provide opportunity for her to get some schooling on the pretense that she might be saved out of the life to which injustice had brought her. And though at first he had not the slightest intention of marrying her, she so played upon this sense of injustice of his, and so

appealed to his own pride and to his appetites and his falsely directed sense of chivalry, that she got him entirely into her power. But once she had him in her net through marriage, she began to drop her mask of pretense, and he found himself not only without the sympathetic understanding which he had supposed he had found in her, but in the hands of a most ruthless parasite, whose one aim was to possess herself of what he had and then to destroy him.

The progress of this man from childhood to maturity reveals a steady turning away from reality, a progressive failure to face and deal with facts, until he was brought to ruin because of the perversions and repressions generated in his emotional life. If, as a small child, he had been understood, so that the rebellions that came up in him had been discharged and replaced with the attitude of confidence and trust toward those who had him in charge, then the sublimation of his emotional life would have begun at that point, and there would not have been developed that tendency to turn away from those genuinely and sincerely interested in him and truly loving him to the false and destructive pretenses of the parasite.

Until we are able to understand and properly educate the emotional life of the child, we shall continue to have history repeat itself in the constantly recurring story of the parasite and its host.

GRAIL OR DRAGON*

Notes on the Prime Task of Humanity

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ONE would like to see the world try out the following bold hypothesis: *that the prime task of society is the destruction of evil.* We should not soon expect a science of the destruction of evil, but we might well hope for more rapid progress in the art of its destruction—as we might say, the malecidal art. As a trivial step in the technique of this malecidal art, I shall below offer a new classification of the various evils of the world, a proposed *Regnum Malorum.* Before inviting the reader into so depressing a kingdom, I feel that I must argue first for the hypothesis itself.

That the prime task of society is the destruction of evil must seem to some a bold hypothesis, to others little more than a truism. Of course, if one talks about a prime task, one is not necessarily talking about the mean task. Moreover, one might be talking of a task primary in time or of a task primary in the logical confrontation of the whole problem of society. It is in the latter sense that I wish to use the term prime. For although it is plain that many persons might well turn from what they are doing to the destruction of circumambient evils, yet there are, no doubt, plenty of good people doing constructive tasks from which it would be a shame to withdraw them. But I want to argue that, in any general confrontation of the total problem of society, we ought to look to the destruction of evil as a primarily indispensable and essential part of our task, logically speaking.

Let me brush aside a few minor objections to the program of the destruction of evil, the malecidal program. How many there are amongst us who have confidence in various political and economic schemes for what they are rather apt to term

* *Editorial note:* Among the papers of Dr. Southard was found this article, which was read at Worcester, Massachusetts, November 14, 1919. We are very glad of the opportunity to place it before the readers of MENTAL HYGIENE. It is Dr. Southard's last contribution to a subject in which he was greatly interested.

social reform or social regeneration. To be sure, these principal words, reform and regeneration, no doubt secretly concede the point that the destruction of evil is the logically initial task of society—else why reform and regeneration at all? Those who see a light through the economic trees are apt to have little patience with those who linger in the forest swamps, as they regard evil. To be sure, if evil were merely negative, the need for reform, regeneration, readjustment, rehabilitation, would not be on the cards for us at all. Hence we find some economists who regard the social primacy of the malecidal art as altogether overbold, in view of political and economic possibilities whose realization would turn the flank of evil altogether, and there are other economists who would consider our hypothesis a truism or a triviality also, since a plan for positive benefit is to their minds identical with the negation of evil. I cannot think that they are right.

Let us turn to another group of thinkers, the juristic group. These men are apt to think that all our interests can, in the end, be secured by legal order. They must regard the evils of this world as in the long run of a very low vitality—doomed to die of malnutrition when the true and positive interests of man are conserved by a reformed legal order. But although the jurists have, no doubt, altogether too strong a hold on the world, yet their grasp is, perhaps, not upon vital organs. Moreover it is to be observed that in the course of decades or centuries jurists come around to the great philosophical, scientific, or ethical views of men more concerned with facts than with the ordering of them. Moreover it is doubtful whether jurists will be found even to consider a hypothesis like ours not couched in legal terms.

There are moralists to consider. Many moralists run so little afoul of evils in their cloistered lives that the technique of evil destruction, the malecidal technique, would strike them as rather a cheap and harmful technique. Having solved, to their thinking, their own individual problems by some species of asceticism, these moralists take a rather anæmic interest in evils which are so easy to avoid, if not to meet. They do not value highly an art of evil destruction, at least when they compare it with some glorious plan of imitating in our lives a lofty and golden norm. Hence we should, no doubt, find

amongst the moralists a few militant spirits who will accept the malecidal program explicitly because they have always acted upon the plan implicitly. A cloud of witnesses amongst the saints will come to mind. Perhaps the moralists will not so readily fail to get the point of the world's difficulty as will sundry economists and jurists. The moralists will probably not so readily confound and identify the positive benefic program with the negative malecidal program. Good sturdy moralists are well aware of what you might call the positiveness of negation, the absoluteness of a relative difficulty—in short, the actuality of evil.

As for the educators—in the more dry and intellectual sense of the term—they will be found emphasizing the senses and the intellect rather than the emotions and the will. They will hardly think of evil as a fit topic for the adolescent mind. And they will have their ideas directed at the adolescent mind rather than at the adult mind. Despite the treasure house of maxims to the contrary, educators will not soon be convinced that the thing for the world to do is to find out what its evils are before it climbs to heights. (See *The Grammarian's Funeral, passim.*) These intellectualists will interpret very literally the phrase, "Get thee behind me, Satan." The *Retro me* was, no doubt, a most malecidal bit of method and did not imply any false "forget-it" philosophy or any notion of putting the devil out of one's mind. No doubt there are maxims and maxims, and looking on the bright side has its adolescent values. As for us poor adults, we have to look upon the dark side, and the first step in malecidal technique will be to measure and probe the kingdom of darkness.

Perhaps we might hope for aid from physicians. Physicians must practically cope with the intenseness of evils. But physicians are immersed, not to say drowned, in the concrete. They do not ordinarily generalize or range about in other branches than their own. They are as guilty in this regard as the jurists, and their modesty has its values. Yet, since they lead the malecidal contingent so far as individual victims of evil are concerned, perhaps we should require some of them to bear witness.

In short, perhaps we should obtain assistance from physicians, from moralists, from economists, from teachers, and

from jurists, in something like the sequence given, when we come seriously to reckon with the main question. Let us turn to this main question.

The destruction of evil—is not this the first study of society? Were evil once destroyed, still would not society's continuing task be the prevention of further evil? Indeed, will it not for centuries be the main task of society to destroy and prevent evil? But what is evil? How shall society proceed? Is not this program for the primary destruction of evil hopelessly vague? How can we prevent what we do not understand?

At first sight a depressing retort. The task of evil destruction looks almost hopeless. Let us for a moment concede the vagueness of the program, though—as will shortly develop—only for a moment. There are enthusiasts, particularly amongst the moralists, who have an alternative plan. They have what they call a constructive plan. In fact, if one begins to talk about the value and pleasure of being a malecide, one is rather apt to be met with the triumphant counter, "But, my dear fellow, why not be constructive?" Why, indeed, why not augment the good in the world? The benefactive plan, as we may call it, must, we think or hope, in the end beat out the devil and all his works; benefactive agencies will, we feel, conquer malefactive agencies. Perhaps even evolution will see to it, and in the struggle for social existence malefactions will be replaced by benefactions, evils with goods.

You will now see the turn of the argument. You said to me that the program for the destruction of evil was a vague one. I replied that the benefactive program for the construction of goodness is a vague one. Is not the program for the greatest good almost hopelessly vague? In any case, how can we lay down even in embryo that which we do not understand any better than we understand evil? Conceding for the moment that we deal with two equally vague programs—for the destruction of evil and for the construction of good—it looks as if we must choose a program on some other basis than the unknown and indefinite nature of the material. We want the good, we want not the evil. If I am equally at a loss to define what is evil and to define what is good, of what avail to me is the ancient maxim, "Knowledge is power"?

But, I submit, the situation is not quite an impasse. It is a truth as old as the hills—indeed the hills were carved out of the old truth—that to tear down is easier than to build up. Destruction is easier than construction. It is easier to scuttle than to cork, to cut than to heal, to ravel than to weave—in short, to analyze than to synthesize. To be sure, the ancient hills look as they had been built up with a purpose, and there are on record a few doubtful experiments like that of Pelion and Ossa. But in point of fact Pelion and Ossa both are products of destruction well enough known to geologists.

If evil and good are both equally hard to define, and if knowledge and wisdom about them both linger, we have a resource left—we can look to our powers. All our human history and all our prehistoric intimations, and perhaps the entire history of our particular evolution of this planet, give us the tip that we shall be quite as well prepared to destroy as to build up. The formula lovers have provided the idea that life reduces to nutrition and reproduction, to the maintenance of the individual and the maintenance of the species, to food and to sex. I do not know whether these formulæ are thoroughgoing. But it is plain that if nutrition is the most important task of every organism, then we that live must be primarily skilled in the powers of destruction; we destroy either the animals or the plants that we must in the last analysis use for our lives. Nor does the history of reproduction fail to show a good many destructive elements; indeed a whole group of workers have regarded the maintenance of species as based on a struggle for existence in which destruction is the big line. Even the history of reproduction in the human race shows a long tale of destructive processes. Nothing seems more synthetic than a honeymoon, yet does not the wedding trip rehearse in simple form the history of millenniums of wife capture? According to the psychologists, as we proceed from militancy to industrialism there is less and less wife capturing in the overt sense, but as between militancy and industrialism who shall say that militancy is not the more ingrained in our natures?

Who, I ask, would not rather be St. George than Sir Galahad? It is indeed a man of rare elevation who would prefer a Holy Grail to a slain dragon. If we may believe the books,

it is easier to slay a dragon than to get a grail. I say, then, that our powers of destruction are more ingrained in us than our powers of construction, and I should like to turn this tendency to account. We should set our powers of destruction on evil. So far as we are destructive, we should be malecides.

A further step in the argument. We should not have conceded above that our ideas of evil are as vague as our ideas of good. Perhaps we know—or *can* know—more about evil than of good. The vocabularies are everywhere full of terms for evil, perhaps fuller of terms for evil than of terms for good. Moreover it is abundantly clear that there are many kinds of evil. It often seems that there are more kinds of evil than there are kinds of good. Pains are sharper than pleasures. Discomforts perturb us more than comfort pleases. If you concede for the sake of your argument that the primacy of the malecidal task is a working hypothesis for society, then the next step is plainly to find out what evils, precisely, there are. The vocabularies divulge their names. Something has been done in the classification of sins by churches and the classification of crimes by courts, but on the whole who will deny that little or nothing has been done in the fundamental ordering of all the multitudinous evils, troubles, difficulties, maladjustments—not merely sins and crimes, but all other forms of evil? Nor can we say that the older estimates of sin and crime based upon the ideas of recompense or retribution must stand to-day.

I think on the whole it will prove easier to classify the evils than to classify the goods. Evil tends to break into *evils* sooner than good into various *goods*. It is much harder to be concrete about goods than to be concrete about evils. The grail is more abstract than the dragon. It is easier to see dragons of many kinds than even to conceive several kinds of grails. Moreover, lest we pity poor Sir Galahad too much, we must remember that the Galahad program was not in all respects a pallid meliorism, but undertook much destruction of evils by the way.

We used George Eliot's good word "meliorate." We are all meliorists, I suppose, if we are social reformers or social workers in any wide sense of those terms. We are all trying

to meliorate the situations we face. Our only question is as to the method of procedure, the technique of the melioration. Shall it be by definitely benefactive routes or indirectly in the malecidal manner? What I feel and am trying to say is, the destruction of definite evils is a better technique to begin with than the construction of indefinite good.

To sum up my points in the reverse order of my consideration here, it may be laid down that:

1. Evil is easier to perceive than good is even to conceive;
2. Evil subdivides into evils more readily than good into goods;
3. Evils get more clearly into our minds than goods do and should by the same token be more definable;
4. As between destruction and construction, we men are built more for destruction than for construction, or at all events are more used to destruction;
5. We should take advantage of this ingrained destructive trend and adopt a "melioristic" technique *in the first instance* of destroying definite, concrete, observable evils rather than of trying to construct indefinite, abstract, hardly conceivable good; and
6. Get the Grail, but First Slay the Dragon.

I have thus given my main arguments for the hypothesis of evil's primacy in the realm of social tasks. I promised a small contribution to the technique of evil's destruction; indeed, if I had nothing concrete to offer, I might be charged, like many of my opponents, with tilting at windmills. Though a bad anticlimax may follow, I must risk it. What I have to propose is a new classification of evils—evils taken, that is to say, in the most general way and gathered for the most general purpose of social attack. I here go upon the conception that the evils of society are quite definite enough to form an aggregate. I think it is possible to hold, furthermore, that the elements in the aggregate can effectively be placed in an order of consideration. And though the order I select may be charged with medical prejudice, and though I myself cannot escape the charge of being a physician, yet I am bound to say that I think the evils do form a well-ordered aggregate of the sort laid down. It is a commonplace of logicians that the kinds of classification of given aggregates are infinite.

This particular classification is leveled at diagnosis and thus in the end also at treatment.

I will present forthwith in tabular form the major groups of evil as I see them.

KINGDOM OF EVILS

(Regnum Malorum)

Diseases or defects of body and mind	*Morbi*
Ignorance: misinformation and educational deficiencies	*Errores*
Vices and bad habits, non-psychopathic	*Vitia*
Legal entanglements	*Litigia*
Poverty and other forms of resourcefulness	*Penuriae*

My whole contention is that it would be to society's prime advantage to take these phenomena as in some sense positive evils, which it would become our duty forthwith to destroy and in future prevent. Still, it is the habit of the world to look upon these matters from another side, from the so-called constructive side, and it may help us here to rehearse our grouping in the more ordinary terms. Thus we might speak of society's task as fivefold—namely, as hygienic, pedagogic, moral, juristic, and economic—and we might describe the values of the world in these terms, specifying the evils that appear as medical, educational, ethical, legal, financial; in short, there is a considerable vocabulary of roughly interchangeable terms for all these conditions, whether we take them on the constructive or on the destructive side.

I shall not here discuss sundry minor questions of terminology. Thus educators sometimes conceive that morality and moral training form a part of the educational program, but I think that on the whole the distinction between mental and moral still holds, at least for practical purposes, and that the blocking together of intellectual teaching and moral training does us logically no good. That probably the teacher ought to be also a moralist, none at the present day can be found to deny, but that the task of conveying information and the task of character formation are in any respect logically identical may well be doubted. Even if there is a rather wavy line between teaching and training as a matter of our schools, nevertheless the problem faced from the standpoint of evils brings very sharply out forthwith the distinction between ignorance on the one hand and vice on the other.

Again, the theologian might inquire whether the evils peculiar to theology—the sins—may enter into this classification. So far as the sins are matters of the authority of a given church for their classification, they can evidently have no general application in communities of different faiths. Roughly speaking, however, the sins, no doubt, with the exception of original sin (not here dealt with) would fall in the group of the *vitia;* and their practical handling is a matter of training, rather than of teaching, as we earlier employ those terms.

The jurist might have a special quarrel with the grouping, since he might wonder how the condition of being at law is in itself an evil. To be sure, we know lawyers are flippantly certain that being at law is somewhat of an evil. We crave to establish in law schools courses of preventive law that shall operate some time in the millennium to the abrogation of all need for being at law, and a program of preventive law has begun to appear in some of the more advanced law schools here in America. It is plain that the innocent parties in all law suits are in an evil plight, whether through loss of time, energy, or money, and it is plain that those who are not innocent are doubly in evil plight, since they are both the causes of the evil and are themselves entangled in their own difficulties. Divorce sins, chancery sins, automobile-ordinance breaking—here are sundry legal entanglements, all of which, I think it is no exaggeration to say, are evils. The word *litigia* appears broad enough to cover not only court cases, but arbitrations and other cases settled out of court.

Where are the evils, the artist inquires, of ugliness, æsthetically speaking? Of course there must be a limbo of evils not covered in these five major groups, and the uglinesses perhaps fall into this limbo. In the meantime I am not entirely sure that the uglinesses of the world are as bad as the beauties of the world are good. In short, an æsthetic theory might be founded upon the hypothesis that beauty is a positive without a negative. However that may be, I have not found it practically necessary in my particular small corner of the world to elect the uglinesses into a major group of evils.

There are certain advantages in taking evils as no more than five. We may count them on the fingers of one hand. We may attach disease to the thumb, ignorance to the index finger;

to vice we may give the central position on the longest or middle finger; to the legal entanglements we may offer the ring finger as a peg, though with an apology to the said finger for its more tender task of time immemorial; and upon the little finger we may hang poverty and the kindred evils, thereby defining for ourselves our conception that when the other evils are done away with, the evils of poverty and the other forms of resourcelessness will remarkably dwindle.

Alas, how complicated a world, with these five groups of evil! How much simpler were we, in common with the lowest animals and plants, to suffer chiefly from disease and to have no other evils in our lot! The primates, and especially man, must make a virtue of their vices, make good out of their evils, achieve construction by means of destruction—such is the burden of our main hypothesis. Three things combine in eight ways, or into seven if we omit the eighth way in which all three are absent. Four things combine in sixteen ways, or fifteen if we omit the negative combination. Five elements combine in thirty-two ways, but the thirty-second is that combination in which all five elements are negative. How fortunate for analysis if the Kingdom of Evils contains but five major groups, for then the combinations will not run beyond the tale of thirty-one, unless perchance there be some among us who belong in the thirty-second group, as stainless as Sir Galahad. The combinations of six elements rise to sixty-four, of seven elements to one hundred twenty-eight, and so on. Accordingly let us derive some comfort from the fact that we are not yet complicated enough, if this analysis holds, to show more than five kinds of trouble.

Thus dogmatically set out, I fancy that the *Regnum Malorum* may appear to some readers as either erroneous or of little practical value. To show that it is erroneous would entail, I believe, the substitution of some other and better scheme, which I think one would gladly adopt, or perhaps the entire point of view of throwing the evils so prominently on the carpet is not well conceived. Yet I think the reader who has come to this point in my discussion, and has not long since thrown the paper down in disgust, will concede at least hypothetical value to the conception. It is clearly impossible for any one nowadays to grasp either the main

facts of medicine, pedagogy, ethics, jurisprudence, and economics, to say nothing of numerous other sciences and arts. All I can offer in favor of the practicability of this scheme is practical work in one of the last resorts of society in its analysis of evil—namely, a psychopathic hospital. The psychiatric branch of medico-social work was for the first time established in a public institution upon a systematic and organized basis in the Psychopathic Hospital at Boston. During the seven years of this work, a considerable progress was made in social case analysis and a considerable list of scientific papers dealing with facts and figures has been issued from the hospital.

I have before me the card catalogues of social difficulties encountered in this hospital. The evils confronted by the staff can, of course, not adequately represent the statistical configuration of evils in the world at large. Primarily we deal with the acute, curable, incipient, and dubious cases of mental disease, such as are not in the first instance commitable as chronic patients to asylums. We constantly confront some of the most acute and delicate situations that the inhabitants of this world have to encounter, but in addition thereto we have a good many school problems and juvenile problems which throw into sharp relief a variety of intellectual and moral issues. The courts of recent years have become acutely interested in the psychiatrist's estimate of delinquents, and many a case of so-called crime turns into a case of mental disease under the scrutiny of the mental expert. Moreover, the poor we have always with us, and they offer us the typical economic difficulties confronted by all social workers. The statistical figures are of no general value as above stated for any appraisal of the world's sheaf of evils. However, as indicative of the general nature of the Psychopathic Hospital problem as it shows itself in the type of social work so-called, I might point out that amongst approximately a thousand so-called "social cases," there were 430 different kinds of problem in the card catalogue, distributed as follows: 72 types of problem were on their face pathological problems, belonging to the evil group above termed *morbi*. The ranging of the intellectual problem was much smaller, only 16 kinds in all *(errores)*. This is not to say that language difficulty and

lack of schooling were not hopeful facts in numbers of cases; the point is that there were 16 kinds of educational problems that came to the surface as main factors in the patients examined. The largest toll of problem types was afforded by the moral group *(vitia)*, of which there were 157. The next largest group is, however, that of legal entanglements *(litigia)*, of which there were 105 different kinds. The poverties and other forms of resourcelessness numbered 80 kinds. Thus, taking the kinds of problem on their face, we found that our hospital was dealing with acute, curable, and incipient and other mild forms of mental disease; that the kinds of problem in the order of strength were as follows:

Moral	157
Legal	105
Economic	80
Medical	72
Educational	16

In appraising this order, it must be remembered that many of the groups might be represented by but a single case, yet the sequence above mentioned is not, I think, a false one save, perhaps, in one respect. If we take these major groups of evil from the standpoint of the individual patients and limit ourselves to the problems that have occurred and re-occurred to a number exceeding fifty, we shall then again find that the moral problems lead. There were 369 cases of moral problem. There were 205 cases of legal difficulty. There were 66 cases of purely medical difficulty. Thus the order of the types as reproduced approximates the order of the number of cases affected; but as intimated above with the exception of this parallelism, there were 539 cases in which economic trouble was found. To be sure the non-economic troubles outnumber the economic ones (640 as against 539), but still the economic difficulties lead in point of number of cases affected. It is, no doubt, this numerical superiority of the economic evil in the world which has attracted the attention of so many reformers and which has incited them to the thought that the proper treatment for the great world evil is a new social, economic, or political system which shall attack the question of poverty and other forms of resourcelessness at first hand.

Nor can I prove from Psychopathic Hospital material (even granting its tremendous repetitions of all the finer shades of

the individual problems in any community) that economic reform should take a secondary place. Yet my general impression, derived from a study of the cases underlying these figures, is that a vast majority of these particular economic troubles is of pathologic and especially of psychopathic origin. The like is true of the great group of the moral problems, so many of which turn out to be not genuine moral problems at all, but a question of certain ingrained psychopathic tendencies which ought to be met in other ways than by mere moral training. (Of course moral training is undertaken in psychopathic cases upon a highly individualized and differentiated and sometimes apparently very partial basis; the point made in the test is that moral training suited for the average man is ordinarily not of the curative kind of ethical attack which we make upon the psychopathic. This is, I grant, debatable ground, but I hardly think the debate is at issue in the text.) Amongst the types of moral problem, there were five species represented in the 369 cases, but of these three are not infrequently, or are perhaps most frequently, psychopathic rather than moral problems. The like holds for marital discord, as we see it in the special atmosphere of the Psychopathic Hospital clinic. As for marital discord in the typical American home, I am far too astute to render an opinion.

Amongst the legal troubles, sex delinquency stands high, but here again in our particular atmosphere we are prejudiced by finding a large majority of our particular sex delinquents psychopathic, a situation which, no doubt, the great outside world does not parallel. For the ways of sex delinquency and the sex habits of the world vary so under the varying conditions of society that it would be the height of absurdity to insist upon any psychopathic nature with sex delinquents as a whole. In the last militant state of the world and even in the reconstruction period, we perceived and are still aware of the effects of a laxity of sex life which can in no wise be regarded as psychopathic.

But these statistical figures are, I insist, of no general value, however interesting they are to the hospital specialist. My point in speaking of them at all is to insist upon the concrete source of the classification here put forward. What right

has any one to claim particular insight into all the evils of the world? Who would have more right to some general notion of the different kinds of evil than workers in a psychopathic hospital? Physicians, nurses, social workers, probation officers, and all the assistants in the medical clinic there might conceivably get a distorted view of the problems of evil in the world—though for my part I am not at all sure that there is any evidence of such distortional view in these malecidal specialists—but whatever their distortion of statistical view, it seems clear that the very last things in point of evil sooner or later fall under the eye of the group of malecides that form psychopathic-hospital staffs. All of which is, perhaps, enough said in justification of the particular concrete source from which these ideas of the *Regnum Malorum* were derived.

EDUCATION OF MENTAL DEFECTIVES IN STATE AND PRIVATE INSTITUTIONS AND IN SPECIAL CLASSES IN PUBLIC SCHOOLS IN THE UNITED STATES

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THE early history of the education of the mental defective, dating from Itard's attempt in 1800 to educate a wild boy found in a forest in the center of France—"this boy could not speak any human tongue and was devoid of all understanding and knowledge"—continuing through the difficult period of great public distrust and doubt, when there was almost a total lack of recognition of the importance of the problem, up to the present-day widespread interest in state care and treatment of mental defectives, has been admirably covered by Doctor Walter E. Fernald in his article, *The Growth of Provision for the Feebleminded in the United States.*[1] The period covered has been one of constant and splendid achievement.

At present there are only five states in the Union that have made no separate provision for the urgent needs of this large, helpless, and potentially dangerous class of dependents. These states are West Virginia, New Mexico, Arizona, Nevada, and Utah.

But no state of the Union is doing more than touching the surface of the problem. Though the great social mischief of which the mentally defective are capable is now becoming fully realized, still not a single state has as yet taken cognizance of one-tenth of its mental defectives.

The care of the feebleminded in separate institutions in the United States per 100,000 general population, and the relative position each state occupies in its recognition and provision for this class in special institutions is shown in the following chart, the material for which has been gathered by the Bureau of Statistics of the National Committee for Mental Hygiene:

[1] MENTAL HYGIENE, Vol. I, pp. 34-59, January, 1917.

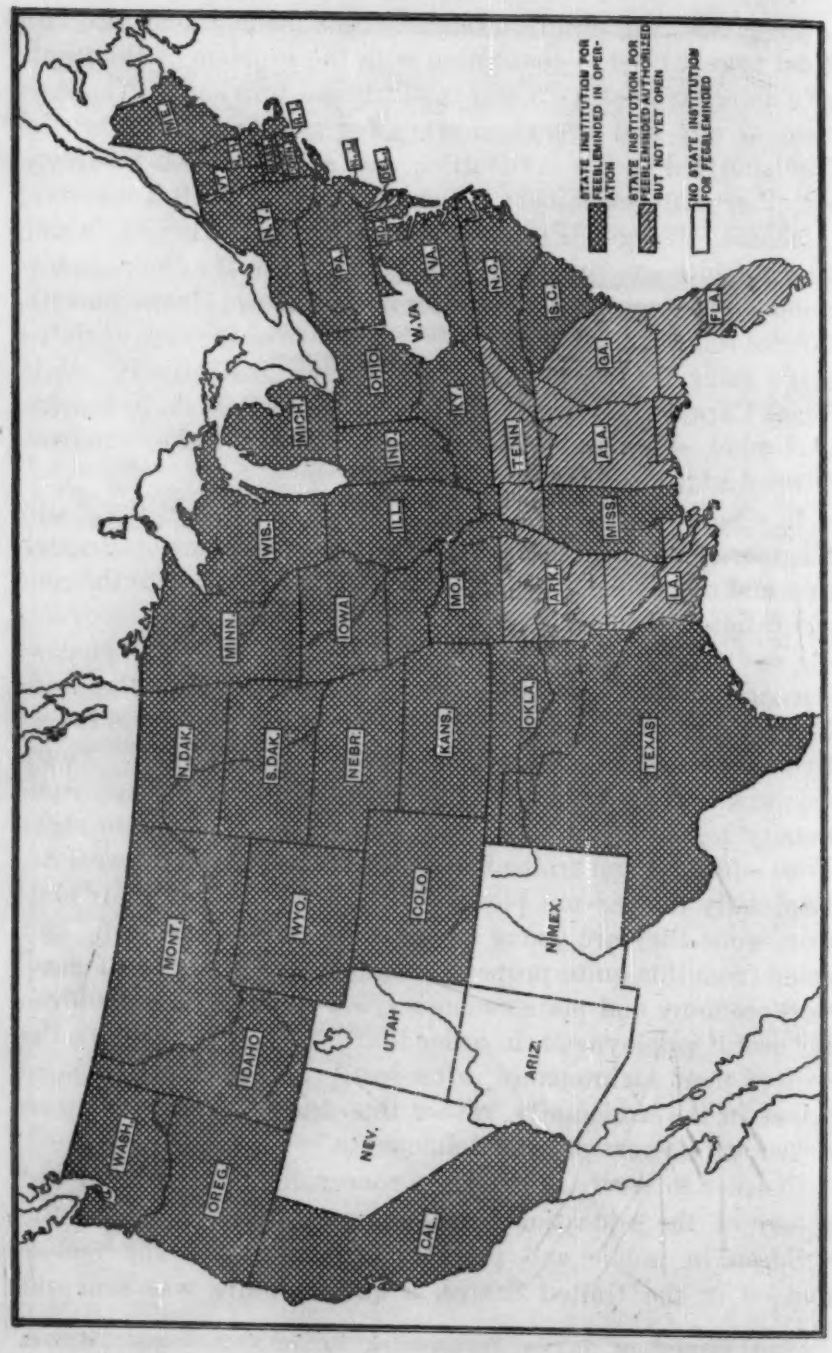
FEEBLEMINDED IN STATE INSTITUTIONS FOR THE FEEBLEMINDED IN THE UNITED STATES, WITH RATES PER 100,000 OF GENERAL POPULATION, JANUARY 1, 1920

Despite all the progress that has been made, the largest and most urgent need in connection with the problem of the mentally defective is still greater institutional provision. The keynote to any and every program for properly handling the feebleminded is the institution, and around it must revolve all other state machinery. During the year 1919 Tennessee, Alabama, Georgia, Florida, Mississippi, and Hawaii, which had not hitherto provided institutional care for their feebleminded, made appropriations for such schools; Massachusetts, Minnesota, Illinois, Indiana, and Wisconsin appropriated large sums for the construction of new institutions; while South Carolina, Oregon, New Jersey, South Dakota, Nebraska, and other states provided appropriations for the construction of additional buildings.

In a recent article[1] we called attention to the fact that, with this increased program for institutional development, greater care and more serious attention were being devoted to the consideration of the types of buildings and methods of constructing and operating such institutions. We now wish to emphasize one of the most important reasons for which the state builds these institutions, and that is the training of the defective children entrusted to it for care and protection. There exists a strong public sentiment in every American community to the effect that every child has a legitimate right to be educated and trained according to its need and capacity. Especially do parents plead for the education of their children while they are young and capable of improvement. But aside from this quite proper sentiment, it is a matter of practical economy and plain common sense to train these children for useful employment, in order that they may either earn the cost of their maintenance in an institution or support themselves in the community, rather than to let them grow up as dependents, vagrants, and delinquents.

In order to secure information concerning the character and extent of the educational training now being given to the children in public and private institutions for the feebleminded in the United States, a questionnaire was sent out

[1] *State Institutions for the Feebleminded*, by V. V. Anderson. MENTAL HYGIENE, Vol. IV, pp. 626-46, July, 1920.



State provision made for the feebleminded in the United States, January, 1921

during January, 1920, asking for data under the following headings:

1. Number of children in institution
2. Number in attendance at school
3. Number of teachers
4. Annual salary of head teacher and assistants
5. Ages of children included in the educable group
   a. Mental age
   b. Chronological age
6. Character and extent of educational training
   a. Sense training. (Extent and character of work done in detail.) Also, number now being instructed in sense training
   b. Grade work. Methods used in teaching; number of grades taught; amount of time each pupil spends in grade work; number of pupils in each grade; and any additional facts bearing upon academic work given
   c. Music. Number of pupils being taught
   d. Physical training
   e. Manual training
   f. Industrial classes
7. Number of mental defectives now in community on parole
8. After-care of paroled and discharged pupils

Replies were received from 30 state institutions and 17 private institutions, caring for 26,774 feebleminded children. The following table shows the state and private institutions represented and the number of children in each institution. It also shows the number and per cent of children in attendance at school. A very wide variation in the amount of educational work done by various institutions is indicated, ranging all the way from no educational provision at all to well organized facilities which provide for the training of as high as 63.80 per cent of the children in these particular institutions.

Table I—Children receiving school instruction in state and private institutions for the feebleminded in the United States

INSTITUTION	Children in Institution	Children in School	
		Number	Per cent
Public			
Sonoma State Home, Eldridge, Cal.	1,456	*	....
Lincoln State School, Lincoln, Ill.	2,214	468	21.2
Indiana School for Feebleminded Youth, Fort Wayne, Ind.	1,469	523	35.6
Iowa Institution for Feebleminded Children, Glenwood, Ia.	1,471	418	28.4
The State Institution for Feebleminded, Frankfort, Ky.	424	*	.....
Maine School for Feebleminded, West Pownal, Me.	346	107	31.2
Wrentham State School, Wrentham, Mass.	1,236	629	50.9
Michigan Home & Training School, Lapeer, Mich.	1,628	384	23.6
Missouri Colony for Feebleminded & Epileptics, Marshall, Mo.	590	95	16.1
Montana School for Deaf & Blind, Boulder, Mont.	100	80	80.0
Nebraska Institution for Feebleminded Youth, Beatrice, Neb.	700	175	25.0
New Hampshire School for Feebleminded, Laconia, N. H.	331	104	31.4
Burlington County Colony, New Lisbon, N. J.	93	†	.....
New York City Children's Hospital, Randall's Island, N. Y	1,528	276	18.1
Rome State School, Rome, N. Y.	1,955	355	16.6
Syracuse State School for Mental Defectives, Syracuse, N. Y	611	340	55.6
Letchworth Village, Thiells, N. Y.	643	170	26.4
The Caswell Training School, Kinston, N. C.	105	67	63.8
State Institution for Feebleminded, Grafton, N. D.	284	102	35.9
Institution for Feebleminded, Columbus, Ohio.	2,486	301	12.1
Oklahoma Institution for Feebleminded, Enid, Okla.	336	84	25.0
State Institution for Feebleminded, Salem, Ore.	478	68	14.2
Pennsylvania Village for Feebleminded Women, Laurelton, Pa.	25	0	.....
State Institution for Feebleminded of Eastern Pennsylvania, Pennhurst, Pa.	1,111	350	31.5
State Institution for Feebleminded of Western Pennsylvania, Polk, Pa.	1,992	463	46.6
State Colony for the Feebleminded, Austin, Texas.	125	55	44.0
Vermont State School for the Feebleminded, Brandon, Vt.	113	38	33.6
State Custodial School, Medical Lake, Wash.	620	315	50.8
Southern Wisconsin Home for Feebleminded & Epileptic, Union Grove, Wis.	105	24	22.9
Wyoming State School for Defectives, Lander, Wyo.	98	35	35.7
Private			
Beverley Farm Home & School for Normal & Backward Children, Godfrey, Ill.	60	35	58.3
Powell School for Backward & Nervous Children, Red Oak, Iowa.	58	44	75.9
Hospital Cottages for Children, Baldwinville, Mass.	113	41	45.1
Miss Moulton's School, Chestnut Hill, Mass.	3	3	100.0
Hillbrow School, Newton, Mass.	7	7	100.0
Parkside Home School, Muskegon, Mich.	5	5	100.0

*Data not received.
†Farm and domestic work only.

Table I—Children receiving school instruction in state and private institutions for the feebleminded in the United States—Concluded

INSTITUTION	Children in Institution	Children in School	
		Number	Per cent
Trowbridge Training School for Unusual Children, Kansas City, Mo	11	11	100.0
Miss Compton's School for Children of Retarded Mentality, St. Louis, Mo	10	10	100.0
Bancroft School for Mentally Subnormal Children, Haddonfield, N. J	50	43	86.0
The Training School, Vineland, N. J	492	165	33.5
The Florence Nightingale School, Katonah, N. Y	24	22	91.7
Pennsylvania Training School for Feebleminded, Elwyn, Pa.	926	207	22.4
The Brookwood School for Backward Children, Lansdowne, Pa	14	13	92.6
The Woods School, Roslyn, Pa	35	35	100.0
The Bristol-Nelson School, Murfreesboro, Tenn	20	20	100.0
Gundry Home & Training School for Feebleminded, Falls Church, Va	99	46	46.5
The St. Coletta Institute, Jefferson, Wis	174	100	57.5

It has been interesting to note the change that has taken place in our attitude toward the value of formal efforts at educating mental defectives. It was the hope of the early pioneers—Itard, Séguin, and others—to arouse the dormant faculties of the feebleminded through the physiological education of the senses in order to develop "the dynamic, perceptive, reflective, and spontaneous functions of youth." For a period real enthusiasm existed over the possibilities in this plan of training, and the early schools were all purely educational in character. Later a reaction set in when it began to be realized that little could ever be accomplished in actually developing the intelligence of feebleminded persons.

When it became fully appreciated that feeblemindedness was incurable, that "once feebleminded always feebleminded," interest in the attempts to educate the feebleminded greatly diminished and public attention became centered upon another element of the problem, the heredity of the feebleminded. Studies of such families as the Jukes,

the Kallikaks, the Ishmaelites, and others, and investigation of pockets of defect in various communities throughout the country brought realization to the public of the social menace and burden of feeblemindedness. Close upon these investigations came reports from state prisons, reformatories, workhouses, jails, houses of correction, and courts, showing the great frequency of feeblemindedness amongst juvenile delinquents, adult criminals, vagrants, prostitutes, and the like. Criminologists began to recognize the mental defective as the backbone of the vast army of recidivists (repeaters) passing through the courts and filling the state and county correctional institutions. There followed a period that may be called the custodial period, marked by the slogan: "Lifelong segregation or sterilization of all feebleminded persons."

We are now entering upon a third period. The practical working out of such theories as permanent segregation or sterilization of all defectives, however good these theories may be, has been found to be impossible in the present state of public conscience; so that such leaders as Fernald are standing for state-wide supervision of all mental defectives, early recognition and diagnosis of every feebleminded child in the public schools, opportunity for special-class training and after-care supervision of every defective child in the state who needs such care, and finally institutional care and intensive training for those unable to profit by special-class instruction in the community. The keynote to this program is, as Fernald says, to be found in the fact that those defectives whose defects are recognized while they are young children, and who receive proper care and training during their childhood, are as a rule not especially troublesome after they have been safely guided through the period of early adolescence; and in many instances, as Bernstein, Wallace, Fernald himself, and others have demonstrated, may be handled with safety and profit in the community. Emphasis is again on the educational phase of the problem of feeblemindedness—fitting the defective for useful service in the institution or, in the case of those for whom it is possible and who have community value, for active lives as respectable, law-abiding, self-supporting members of society. It is of interest, therefore, to know just what the institutions of

the country are doing in the way of training their educable children.

Public and Private Institutions for the Mentally Defective

The following table indicates the equipment of each institution in the way of teachers, the number of pupils per teacher, and the maximum and minimum salaries received by teachers.

Table II—Teachers in institutions for the feebleminded, ratio of pupils to teachers, and salaries of head teachers and other teachers

INSTITUTION	Teachers	Pupils per Teacher	Salaries			
			Head Teacher		Other Teachers	
			Minimum	Maximum	Minimum	Maximum
Public						
Sonoma State Home	8	.....	$1,080	.....	900	.....
Lincoln State School	15	31	1,200	2,133.24	780	1,080
Indiana School for Feebleminded Youth	16	43	.....	*1,080	576	*648
Iowa Institution for Feebleminded Children	17	24	.....	750	400	500
Maine School for Feebleminded	3	35	780	1,300	780	1,040
Wrentham State School	15	41	960	1,320	540	840
Michigan Home and Training School	15	25	1,000	1,200	720	900
Missouri Colony for Feebleminded and Epileptics	†	†	.....	900	.....	600
Montana School for Deaf and Blind	5	16	.....	840	600	720
Nebraska Institution for Feebleminded Youth	5	35	900	900	660	780
New Hampshire School for Feebleminded	4	26	.....	‡750	550	‡600
New York City Children's Hospital	27	10	.....	1,700	696	1,200
Rome State School	12	29	900	1,200	600	720
Syracuse State School for Mental Defectives	22	15	.....	‡990	400	600
Letchworth Village	6	28	.....	900	.....	720
The Caswell Training School	1	67	‡900	.....	.....	.....
State Institution for Feebleminded, North Dakota	5	20	.....	1,080	550	650

* Part maintenance
‡ For less than 12 months
† Not reported
For addresses of institutions see Table I

Table II—Teachers in institutions for the feebleminded, ratio of pupils to teachers, and salaries of head teachers and other teachers—Concluded

INSTITUTION	Teachers	Pupils per Teacher	Salaries			
			Head teacher		Other teachers	
			Minimum	Maximum	Minimum	Maximum
Institution for Feebleminded, Ohio	17	16	.....	600	400	570
Oklahoma Institution for Feebleminded	3	28	600	600	.....	.....
State Institution for Feebleminded, Oregon	5	13	750	.....	600	.....
State Institution for Feebleminded of Eastern Pennsylvania	12	29	.....	750	550	600
State Institution for Feebleminded, of Western Pennsylvania	17	27	600	900	540	720
State Colony for Feebleminded, Texas	3	18	.....	1,200	.....	720
Vermont State School for Feebleminded	1	38	450	.....	.....	.....
State Custodial School, Washington	7	45	.....	660	.....	.....
Southern Wisconsin Home for Feebleminded and Epileptic	1	24	800	.....	.....	.....
Wyoming State School for Defectives	2	17	900	1,200	900	900
PRIVATE						
Beverley Farm Home and School for Normal and Backward Children	2	17	300	.....	.....	.....
Powell School for Backward and Nervous Children	4	11	1,000	.....	.....	.....
Hospital Cottages for Children	2	20	†	.....	.....	.....
Miss Moulton's School	1	3	†	.....	.....	.....
Hillbrow School	3	2	.....	1,000	.....	650
Parkside Home School	2	3	†	.....	.....	.....
Trowbridge Training School	3	3	†	.....	.....	.....
Miss Compton's School for Children of Retarded Mentality	5	2	†	.....	.....	.....
Bancroft School for Mentally Subnormal Children	13	3	1,380	3,480	1,140	1,320
The Training School	12	13	.....	1,350	420	900
The Florence Nightingale School	3	7	1,200	.....	.....	.....
Pennsylvania Training School for Feebleminded	15	13	1,020	.....	360	600
The Brookwood School for Backward Children	5	2	.....	.....	480	600
The Woods School	10	4	†	.....	.....	.....
The Bristol-Nelson School	†	.....	780	.....	360	480
Gundry Home and Training School for Feebleminded	3	15	600	.....	480	.....
The St. Coletta Institute	10	10	†	.....	.....	.....

† Not reported

For addresses of institutions see Table I

Excluding certain institutions that have no school work at all, we find that the number of teachers per institution varies all the way from one to twenty-seven. The New York City Children's Hospital and School at Randall's Island, among the public institutions, has both the largest number of teachers and the smallest group of pupils (10) to each teacher. The salaries at this institution are also the highest reported.

For satisfactory work in the training of defectives, it is generally agreed that small classes are necessary. Most institutional men complain of the great lack of funds for an adequate teaching staff. Many would like to have not more than fifteen pupils per teacher, although the majority of public institutions for the feebleminded are having to conduct their school work on the basis of thirty-odd pupils to a teacher. The character of educational work done in these institutions cannot, to be sure, be judged purely from the size of the teaching staff or the salaries paid, for there are certain public institutions in this country where the character of training given is highly efficient although the number of teachers is comparatively small and the total number of pupils per teacher large. However, the success of the educational work in these institutions is dependent upon the skill and zeal of certain exceptional teachers, who are succeeding in spite of their handicaps—a personality factor that cannot be estimated in a general study of this kind. Other things being equal, a fair judgment of the educational work of an institution can be based on the size and equipment of the teaching staff.

Ages Included in Educable Groups

The reports show that the chronological ages of the pupils have a wide range (three years to sixty years). The mental ages range from one year to sixteen years, although in general the range is from three years to twelve years.

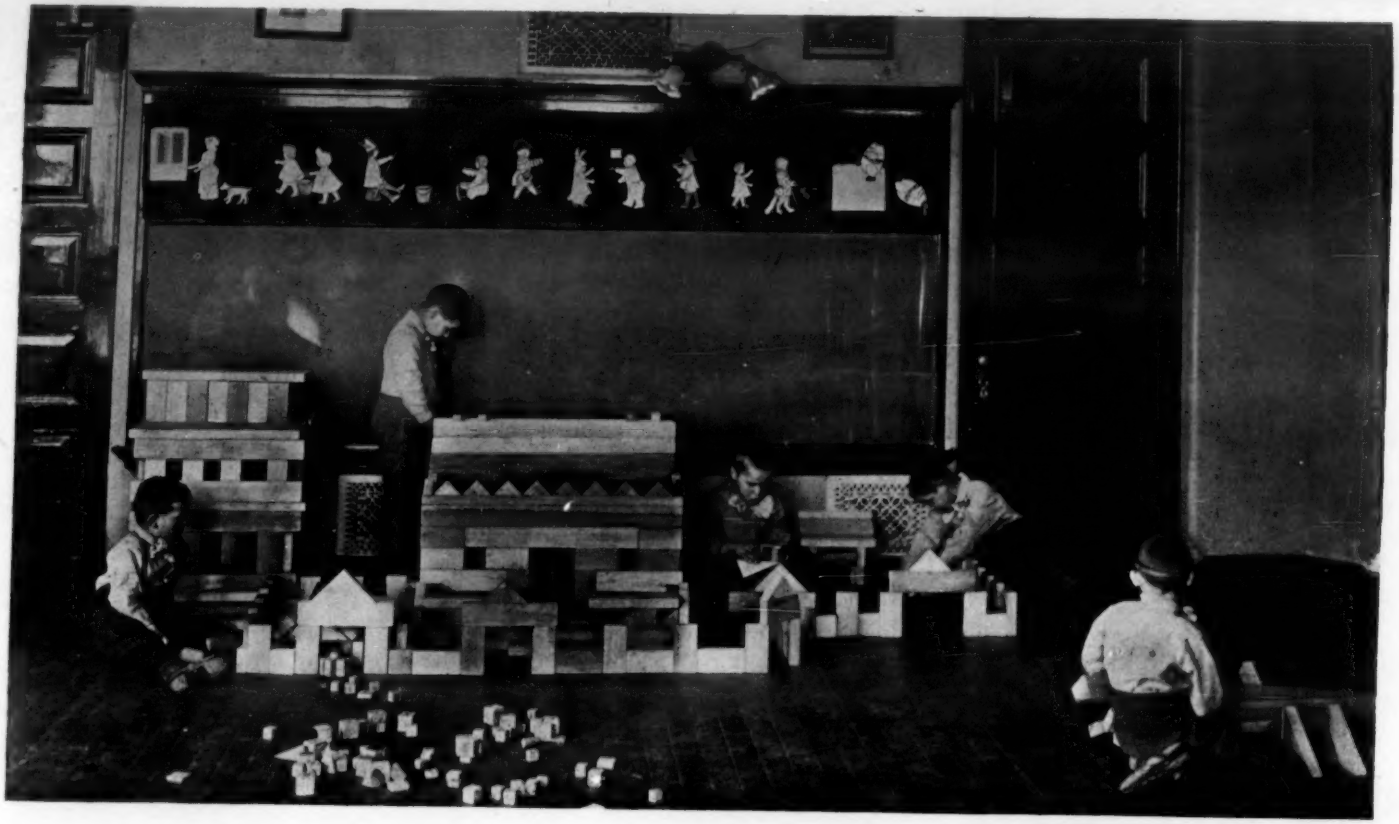
It is doubtful whether any form of school training shows permanent results for children below the mental age of three years. Many men are beginning to doubt the wisdom of keeping idiots, for whom there is nothing to offer but custodial care, for years and years in the kindergarten.

In a study of 108 defective children carried out by Miss Lindley, not a single defective of seven years or less Binet age was ever observed to read.

Sense Training

The development of the brain is indissolubly connected with the use of the sensory apparatus. Touch, taste, smell, hearing, vision, and muscle-tendon sense are the avenues through which the brain receives stimuli for the development of the mind. Sense training, however, does not necessarily need to be a lesson by itself. Every subject taught during the day may lend itself to the training of the senses. Dr. George L. Wallace, Superintendent of the Wrentham (Massachusetts) State School, writes in regard to sense training: "The children's attention is first secured by means of simple games such as colored bean-bag throwing, ball throwing, clapping of hands, marching, stopping and starting at a given signal. In the formal sense work, the children are first taught to associate the old and the new; then the use of each object; then the name. The child associates sugar with candy, turpentine with the cleaning of the floors, the sound of the bell with the dinner bell. From this he is trained to notice the changes in the grouping of objects, persons, etc. Much color work is used; colored blocks are matched to colored squares of cloth. The child picks out various objects in the room that are the same color as his block. Blocks are later matched in regard to color, size, and form. The name of the color is not taught, but is learned incidentally. Simple, active games are used. Circle games and singing games with music. Often colored blocks with bean bags, balls, and tops are used in connection with these games."

"In training the children to dress themselves, button strips—two pieces of cloth, buttons on one and buttonholes on the other—are used. Shoe lacing is also taught. Time is also spent in teaching neatness in dress and manners. In preparation for hand sewing, large, heavy cardboard cards with large holes are used. Colored shoe laces are drawn through. From these the children progress to smaller cards, using worsted and a needle, then to plain sewing—sewing on buttons, etc.



Kindergarten

Grade work

Peg boards, picking up of paper, pincushion work, etc., are used. Instruction is given in carrying wood and stones from one definite location and placing them in another definite location; in shoveling sand from one place to another, etc.; the use of the hammer, first pounding blocks, then using large nails, and gradually using smaller ones; the use of the grub hoe; and, finally, planting and the care of the garden."

This investigation shows that 23 out of 30 public institutions, and 14 out of 18 private institutions, are daily giving formal sense training.

Grade Work

Twenty-three of the 30 state institutions studied are giving regular grade work. In four the scholastic work is not scheduled by grades. In two institutions there is no school work given at all. Sixteen out of 18 private institutions are giving regular grade work.

The Superintendent of the Wyoming State School for Defectives at Lander, Dr. C. T. Jones, writes in regard to methods: "All work is motivated. Arithmetic is taught by playing store, writing for the purpose of letter writing, etc., etc. All school work is correlated with activities in the institution. Each child is given a mental age rating. On the basis of this rating, it is decided about what grade of academic work can be expected from him. He is then given pedagogical tests of achievement, and if he is not up to what can be reasonably expected of him, he is given special training in the lines where he shows the greatest weakness. No child is forced beyond what can be expected from him in view of his mental level."

Dr. O. H. Cobb, Superintendent of the Syracuse State School for Mental Defectives, says regarding methods in grade work, "An adaptation of many methods, plus drill to the *n*th degree. Attempt is made to follow the work required for each grade by the New York State Syllabus in reading, writing, and numbers. These are the only subjects taught except some geography in the 4th and 5th grades."

From the returns it was found that approximately 87 per cent of the pupils who are doing school work in the various institutions for the feebleminded were in the first four grades.

The number of hours pupils spend each day in regular grade work varies in the different institutions from one-half to one and one-half hours in one to five hours in two, but the average amount of time is from one to three hours a day.

Music

Twenty-five state institutions out of 30 studied report systematic efforts in the way of training children in music. Twelve private institutions out of 18 studied report similar training. Twenty-one institutions maintain pupil bands and orchestras. All institutional men are familiar with the fact that music is not only an important element in the happiness of defective children, but a most wonderful factor in its disciplinary effects on these children.

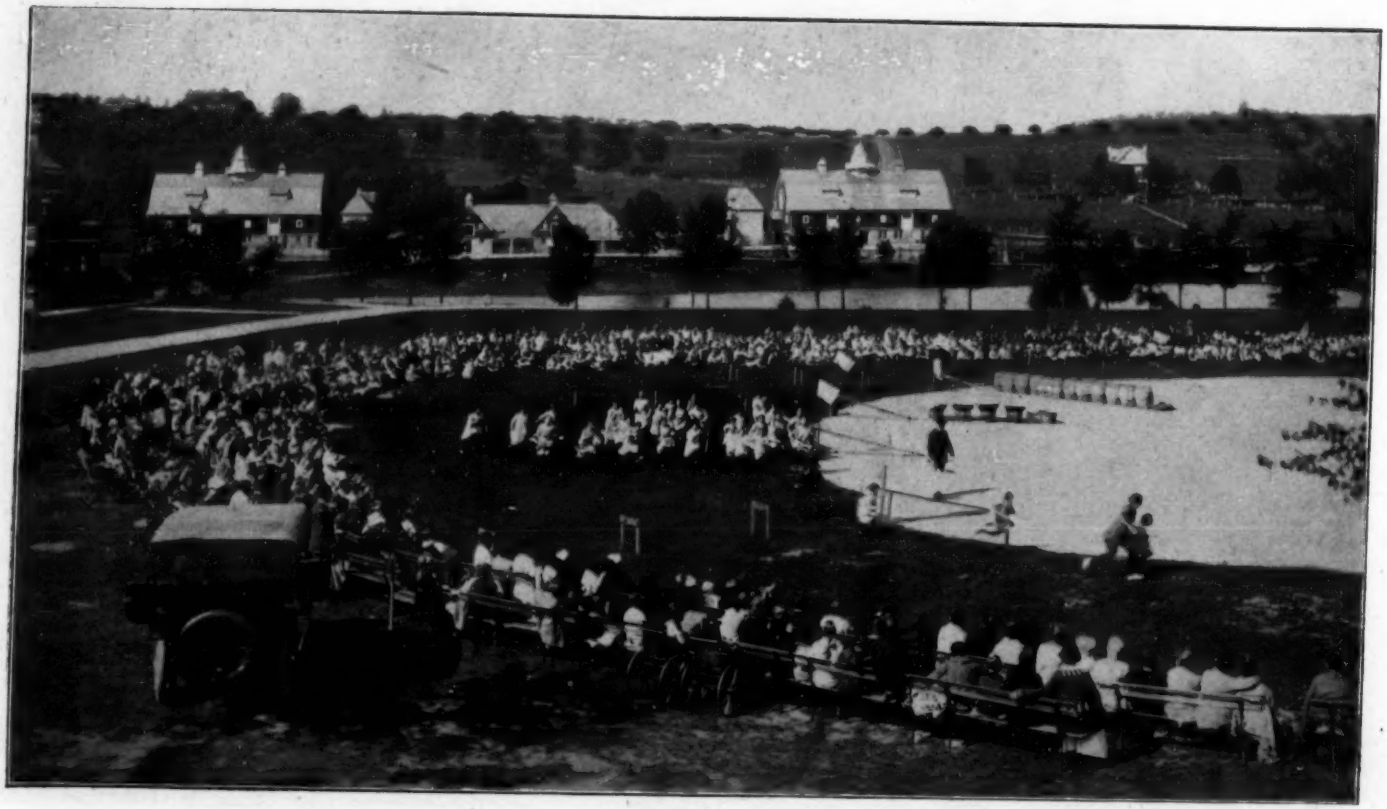
Institutions Maintaining Bands or Orchestras

1. Sonoma State Home, Eldridge, Cal.
2. Missouri Colony for Feebleminded and Epileptics, Marshall, Mo.
3. Rome State School, Rome, N. Y.
4. Iowa Institution for Feebleminded Children, Glenwood, Ia.
5. Syracuse State School for Mental Defectives, Syracuse, N. Y.
6. Michigan Home & Training School, Lapeer, Mich.
7. Institution for Feebleminded, Columbus, O.
8. Nebraska Institution for Feebleminded Youth, Beatrice, Neb.
9. New York City Children's Hospital, Randall's Island, N. Y.
10. Letchworth Village, Thiells, N. Y.
11. State Institution for Feebleminded, Grafton, N. D.
12. Pennsylvania Training School for Feebleminded, Elwyn, Pa.
13. The St. Coletta Institute, Jefferson, Wis.
14. Powell School for Backward and Nervous Children, Red Oak, Ia.
15. State Institution for Feebleminded of Western Pennsylvania, Polk, Pa.
16. Wrentham State School, Wrentham, Mass.
17. Lincoln State School, Lincoln, Ill.
18. The Training School, Vineland, N. J.
19. State Institution for Feebleminded of Eastern Pennsylvania, Pennhurst, Pa.
20. Indiana School for Feebleminded Youth, Fort Wayne, Ind.
21. Massachusetts School for the Feebleminded, Waverley, Mass.

Physical Training

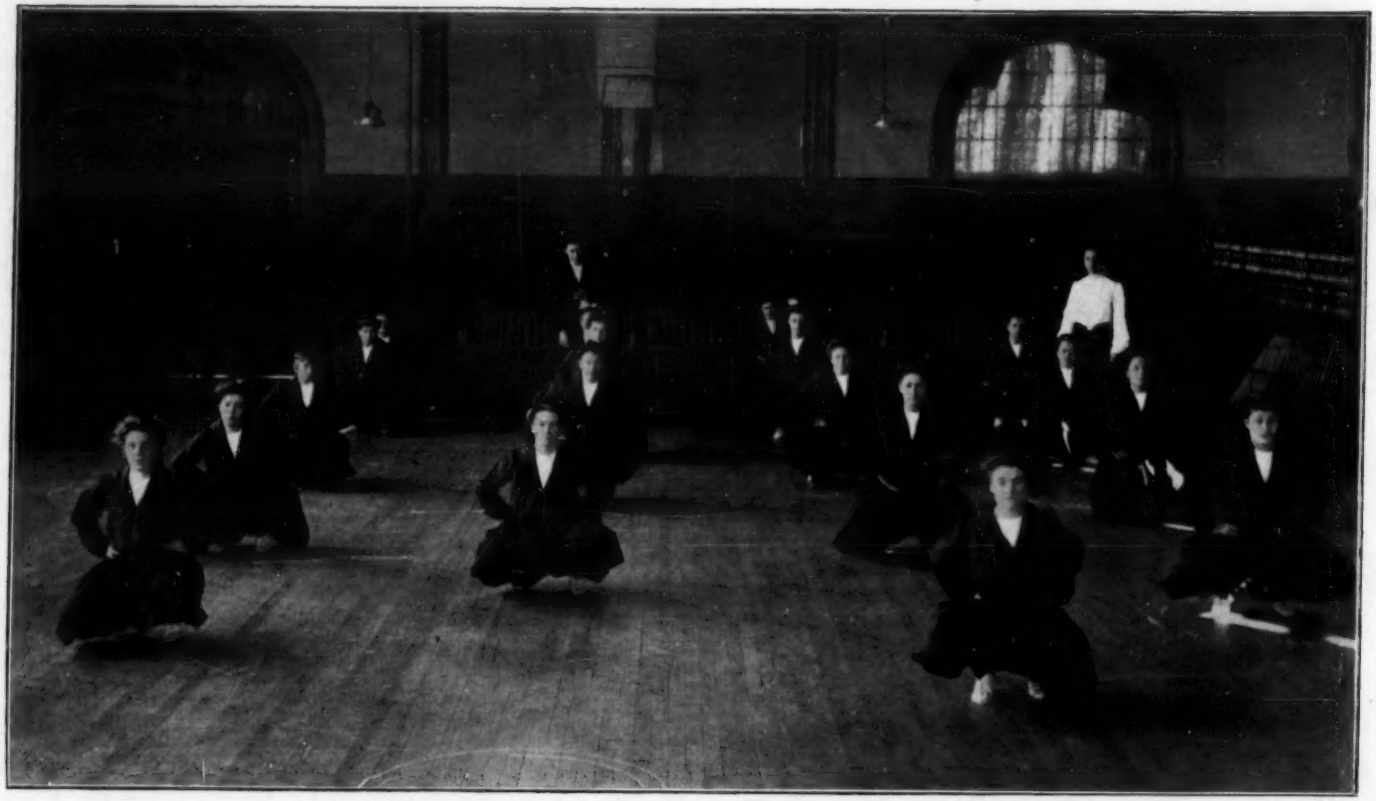
Physical training has for its aims the improvement of physical health, the correction of physical defects, the building up of physical strength, replacing the shuffling, awkward gait with a graceful carriage, putting "pep," power, and self-con-

An institution orchestra



Field day

Physical training for boys



Physical training for girls

fidence into the weak, inactive, indolent, apathetic, suggestible, and inadequate personality.

The importance of this phase of educational work is quite obvious. One who has visited the gymnasium at Waverley comes away not only with a conviction of its value as a part of the curriculum of a school for the feebleminded, but with a real enthusiasm as to the possibilities to be derived from this work. The prime requisite for securing successful results from the teaching of physical training to the defective is a well-trained teacher.

Twenty-three out of the 30 state institutions included in this study report regular, systematic work in physical training. Only 13 of the institutions were equipped with gymnasiums, while 14 had regularly employed physical directors. Sixteen out of the 17 private institutions report regular physical training, 11 have gymnasiums, and 4 have regularly employed physical directors. One institution reports: "The character of training consists of games to arouse enthusiasm, gymnastic exercises for posture and attention, marching for carriage, for alertness and rhythm; drill work for rhythm and grace; dancing, folk and social, for rhythm and grace, etc."

Basket ball and indoor baseball, field-day sports and the like are part of the physical-training work in certain institutions.

Table III—Physical training of children in institutions for the feebleminded

INSTITUTION*	Physical Directors	Gymnasiums	Children Receiving Physical Training	
			Number	Per cent
PUBLIC				
Sonoma State Home	Yes	Yes	183	12.5
Lincoln State School	Yes	Yes	230	10.4
Indiana School for Feebleminded Youth	Yes	Yes	307	20.9
Iowa Institution for Feebleminded Children	Yes	No	79	5.4
Kentucky State Institution for Feebleminded	.....	.....	.....	.....
Maine School for Feebleminded	No	No	72	20.8
Wrentham State School	Yes	Yes	420	33.9
Michigan Home & Training School	Yes	Yes	266	16.3
Missouri Colony for Feebleminded & Epileptics	Yes	Yes	60	10.1
Montana School for Deaf & Blind	No	No	"all"	100.0
Nebraska Institution for Feebleminded Youth	Yes	.....	53	7.6
New Hampshire School for Feebleminded	No	No	104	31.4
Burlington County Colony	†	.....	.....	.....
New York City Children's Hospital	Yes	Yes	276	18.1
Rome State School	.....	.....	900	45.9
Syracuse State School for Mental Defectives	Yes	Yes	149	24.4
Letchworth Village	Yes	Yes	190	29.5
The Caswell Training School	.....	.....	.....	.....
North Dakota State Institution for Feebleminded	No	No	37	13.0
Ohio Institution for Feebleminded	Yes	Yes	235	9.5
Oklahoma Institution for Feebleminded	No	No	.....	.....
Oregon State Institution for Feebleminded	Yes	Yes	137	28.7
Pennsylvania Village for Feebleminded Women	.....	.....	.....	.....
State Institution for Feebleminded of Eastern Pennsylvania	.....	No	.....	.....
State Institution for Feebleminded of Western Pennsylvania	Yes	Yes	280	14.6
Texas State Colony for Feebleminded	.....	No	45	36.0
Vermont State School for the Feebleminded	No	No	.....	.....
Washington State Custodial School	No	No	100	16.1
Southern Wisconsin Home for Feebleminded & Epileptic	No	No	24	22.9
Wyoming State School for Defectives	No	No	32	32.7
PRIVATE				
Beverley Farm Home & School for Normal & Backward Children	No	Yes	40	66.7
Powell School for Backward & Nervous Children	No	Yes	44	75.9
Hospital Cottages for Children	.....	No	34	30.1
Miss Moulton's School	.....	No	3	100.0
Hillbrow School	.....	Yes	7	100.0
Parkside Home School	No	Yes	5	100.0
Trowbridge Training School for Unusual Children	No	Yes	11	100.0
Miss Compton's School for Children of Retarded Mentality	Yes	.....	10	100.0
Bancroft School for Mentally Subnormal Children	Yes	Yes	43	86.0
The Vineland Training School	Yes	Yes	88	17.9

*For addresses of institutions see Table I.
†Farm and domestic work only.

Table III—Physical training of children in institutions for the feebleminded—Concluded

INSTITUTION*	Physical Directors	Gymnasiums	Children Receiving Physical Tarining	
			Number	Per cent
The Florence Nightingale School	No	Yes	22	91.7
Pennsylvania Training School for Feebleminded	No	Yes	.....	.....
The Brookwood School for Backward Children	Yes	.....	13	92.9
The Woods School	Yes	Yes	35	100.0
The Bristol-Nelson School	.....	.....	20	100.0
Gundry Home & Training School for Feebleminded	No	Yes	42	42.4
The St. Coletta Institute	No	No	100	57.5

*For addresses of institutions see Table I.

All the fittings of a regular gymnasium, such as walking beams, steel bars, ladders, ropes, rings, horses, Indian clubs, dumb-bells, wands, basket balls, and nets, are required.

Manual Training and Industrial Classes

Fernald says: "In this education by doing, we not only have a very valuable means of exercising and developing the dormant faculties and defective bodies of our pupils, but at the same time we are training them to become useful men and women."

Goddard says: "The one thing that fits all of these children, the one thing that draws out whatever is to be drawn out of them, is training of the hand, manual training, industrial training."

Our questionnaire indicates that 20 out of 30 state institutions are equipped for and are giving manual training. Fifteen of these institutions have special teachers particularly trained and fitted for just this type of work. Fourteen of the 17 private institutions report regular manual training. Seven of these institutions have teachers specially trained for giving such instruction.

Twenty-five state institutions and 13 private institutions have regularly organized industrial classes. The various

types of work reported are as follows: Basketry, baking, brickmaking, broom and brush making, building, caning, carpentry, domestic science, dressmaking, engine and storeroom work, fancy work, farming, gardening, housework, lace making, laundry work, mattress making, painting, plumbing, poultry raising, printing, net work, sewing (plain), steamfitting, shoemaking, stock raising, tailoring, weaving, woodwork.

Manual and industrial training is rapidly becoming the most prominent feature of the educational training now being given in our best institutions for the feebleminded. Here are being carried on by the pupils themselves carpentry, painting, printing, brick making, shoemaking, tailoring, dressmaking (certain institutions making all of the shoes, dresses, and suits worn by the children), broom and mattress making (one institution now making all the brooms being used in every state institution in the state in which it is located), stock raising, dairying, farming, domestic work, and other industries. These not only prove profitable in the way of financial return to the institution, but form a splendid outlet for the energies of the overactive and disciplinary cases, besides offering an occupational basis for those who are later to be placed under supervision in the community.

Parole

It has been fairly well determined that the average adult male defective who is not handicapped by serious difficulties of personality, who has been properly trained in habits of obedience and industry, and who is adequately protected from temptations and evil associates can be safely paroled into the community. Dr. Fernald's report of the results of a survey made of 646 patients discharged into the community from the Massachusetts School for the Feebleminded during a period of 25 years is most significant.[1] He says frankly of these cases: "We honestly believed that nearly all of these people should remain in the institution indefinitely. The majority

[1] After-care Study of the Patients Discharged from Waverley for a Period of Twenty-five Years, by Walter E. Fernald. *Ungraded*, Vol. V., pp. 25-31, November, 1919.

Rug, basket, and hammock making

Weaving

Dressmaking

Knitting

were dismissed under protest. Not a few of the males took matters into their own hands and ran away."

Of these cases there were 470 males and 176 females.

The following table, quoted from Dr. Fernald's article, shows what actually happened to the 470 males:

Earning a living without supervision	28
Working for wages supervised at home	86
Working at home, no wages	77
Living at home, not able to work	59
Arrested, but not sentenced	23
Sentenced to penal institutions	32
Committed to other institutions	43
Readmitted to Waverley	68
Died	54
Total	470

"Apparently the cases represented in the first four groups, a total of 250, constituted no serious menace to the community at the time of the investigation," says Dr. Fernald.

The 176 female cases are summed up as follows:

Married (11 doing well)	27
Self-supporting and self-controlling, unmarried	8
Living at home under supervision	32
Living at home, not able to do much work	23
Committed to other institutions	29
Died	24
Readmitted to Waverley	33
Total	176

The 27 married women mentioned above had 50 children, 17 of the children had died and 33 were living. The social worker who saw these children was not sure that any of them were defective. "Nearly all of the women had married men whose social status was rather above that of their own parents."

Speaking of the discharged male defectives, Dr. Fernald says: "Their weekly wages ran from $8 to $36. . . . One is in business for himself as a sign painter, a trade he learned at the school. . . . One had saved $2,000; another had bought a house," etc., etc.

"There was a surprisingly small amount of criminality and sex offenses, and especially of illegitimacy. We may

hope for a much better record when we have extra-institutional visitation and supervision of all discharged cases. . . . The survey shows that there are bad defectives and good defectives. . . . It is most important that the limited facilities for segregation should be used for the many who can be protected in no other way."

Dr. Charles E. Bernstein, Superintendent of the Rome State School for Mental Defectives at Rome, New York, owing to the fact that many discharged from the institution drifted into the streets and into the courts because of the absence of intelligent supervision, developed a colony plan for handling his girls in the community.[1] The colony represents a step from the institution to the community. Dr. Bernstein is placing groups of high-grade girls, under the careful supervision of well-trained and trusted matrons, at work in domestic service in carefully selected homes in certain localities of the state. A house is rented to which they return at night, and all the comforts and pleasures, as well as the restraints, of regular home life are thrown about them. Eleven boys' colonies and 10 girls' colonies have been developed. Of 200 girls who have passed through the girls' colonies, only 35 have been returned to the parent institution, leaving 165 still maintaining themselves in the community.

As has been pointed out, there are good and bad mental defectives. Some feebleminded individuals possess a very definite community value, are fairly efficient industrially and adaptable socially, and can be properly supervised outside of the institution. There are other feebleminded individuals, popularly known as bad and vicious mental defectives, who possess traits of character and handicaps of personality of such nature as to make it wholly impossible to handle them satisfactorily in the community.

Institutional men throughout the country are now beginning to give serious attention to the possibilities that parole offers in the way of furnishing additional beds to those mental defectives in the community who are urgently in need of institutional care, at the same time that it returns to the com-

1 See *Colony and Extra-Institutional Care for the Feebleminded*, by Charles Bernstein. MENTAL HYGIENE, Vol. IV, pp. 1-24, January, 1920.

munity, under careful supervision, well-trained individuals who are capable of self-support and give little or no promise of antisocial behavior.

This study shows that 19 out of 30 institutions are paroling mental defectives into the community. In 5 of these institutions the work is being developed as a serious and important phase of the institutional activities. Five institutions have regularly appointed parole officers or supervising agents. One institution has 504 cases on parole. In 14 institutions the work is more or less new and as yet largely on trial, while the remaining institutions evidently have no parole whatever. The following institutions report paroles: Rome State School, Rome, N. Y.; Syracuse State School for Mental Defectives, Syracuse, N. Y.; Michigan Home and Training School, Lapeer, Mich.; Maine School for Feebleminded, West Pownal, Me.; Sonoma State Home, Eldridge, Cal.; The Training School, Vineland, N. J.; Oklahoma Institution for Feebleminded, Enid, Okla.; State Colony for Feebleminded, Austin, Tex.; Nebraska Institution for Feebleminded Youth, Beatrice, Neb.; Letchworth Village, Thiells, N. Y.; Burlington County Colony, New Lisbon, N. J.; Southern Wisconsin Home for Feebleminded and Epileptic, Union Grove, Wis.; State Institution for Feebleminded of Western Pennsylvania, Polk, Pa.; New Hampshire School for Feebleminded, Laconia, N. H.; Wrentham State School, Wrentham, Mass.; Wyoming State School for Defectives, Lander, Wyo.; Lincoln State School, Lincoln, Ill.; Missouri Colony for Feebleminded and Epileptics, Marshall, Mo.; Massachusetts School for the Feebleminded, Waverley, Mass.

This, the most hopeful aspect of work in behalf of mental defectives, is rapidly coming to the foreground of discussion, and gives promise, where carefully planned and properly worked out, of becoming the most prominent feature of the activities of future institutions for the feebleminded.

Special Classes in the Public Schools

As a matter of fact, despite whatever theories there may be as to the complete institutional care of all mental defectives, the great majority must be handled one way or

another in the community; and if they are ever to receive any training at all, it will have to be given to them through the public schools.

In size and importance, there is probably no other question more vital to the good of our elementary public school than, What shall be done with our mentally defective children? Between 1 and 2 per cent of the public-school children are unable to profit by the regular grade work because of mental deficiency. In every school district are to be found these unfortunates who are not able to keep step with the rank and file of children. Their stupidity marks them as the dunces in the school, and their simple-mindedness renders them the constant butt of jokes and the perennial source of childish ridicule. They are a burden to the teacher and a constant menace and hindrance to the other pupils in the classes.

But while in school the mentally defective child is decidedly a misfit—he can do no more than his defective brain will enable him to do—in the community in later life the sad combination of his childish mind and his adult years brings him into conflict with laws, customs, and rules of conduct, all of which have been devised for persons whose minds, as well as bodies, are those of adults; so that we find the defective dependent upon charity because of his inability to make a living, and delinquent and immoral because of his inability to appreciate and measure up to adult standards of conduct, or to understand laws, or to protect himself from the advances of others, or to deal with the problems of his own sexual life as the standards of the community require. Jails and brothels, prisons and reformatories, venereal clinics, almshouses, and outdoor relief societies show the price and penalty we are paying for our neglect to provide specialized training in the public schools and lifelong supervision in the community, or institutional care and training at a time when prevention of antisocial tendencies is possible.

Up to the present time educational authorities have shown all too little inclination to appreciate the magnitude and importance of the problem furnished by the mentally defective child.

During the summer and fall of 1919, a survey was made of the special classes for mental defectives in the public schools of the United States. The method employed in obtaining information was by means of a questionnaire sent to school superintendents, principals, and supervisors in 155 cities in the United States. The questionnaire asked for the following data:

1. Total number of pupils enrolled in all public schools, not including high school.
2. Number of classes for mentally deficient children.
3. Number of pupils in such classes.
4. Date of organization of first special class.
5. Are special classes specifically authorized by state law, or are they provided for by state law?
6. Are the special classes segregated in a separate building?
7. Is a distinction made between "special classes" and "ungraded classes" in your schools?
8. How are pupils selected for special instruction? State what tests, if any, are used.
9. Who conducts examinations? Name and title.
10. Course of study and kind of instruction given in such special classes.
11. Author of industrial equipment.
12. What methods of instruction are used?
13. Number of teachers employed in such special classes. What preparation on the part of the teacher is required for this work?
14. Salaries, minimum and maximum, paid to the supervisors and teachers of special classes.
15. What have been the results of the special class work?
16. Are defective pupils supervised outside of schools hours? If so, how and to what extent?
17. What supervision is given these children after they have left school?
18. Is there a department of vocational guidance in your school system? If so, what has been its experience in placing defective children?
19. Name of supervisor of special classes.
20. Are mental clinics for school children conducted? If so, by whom and at what hours?
21. Suggestions relative to the development and usefulness of special classes.

One hundred and twenty-five replies were received, showing cordial coöperation on the part of the school officials. Seventeen cities stated that they had no special classes. The following study contains data bearing upon the organization and equipment of special classes in 108 cities in the United States. These 108 replies represent 1,177 special classes, providing for 21,251 defective pupils. Thirty states are represented in this study:

Alabama	Kentucky	Ohio
California	Massachusetts	Oklahoma
Colorado	Michigan	Oregon
Connecticut	Minnesota	Pennsylvania
District of Columbia	Missouri	Rhode Island
Georgia	Montana	South Carolina
Illinois	Nebraska	Texas
Iowa	New Hampshire	Virginia
Indiana	New Jersey	Washington
Kansas	New York	Wisconsin

The laws of few states require the formation of special classes in the public schools for mentally defective children. In the last three years, however, special classes have by law been made compulsory in five states—Massachusetts, Pennsylvania, Missouri, New Jersey, and New York. In these five states plans are now under way for the recognition and training of every defective child in the state. It is interesting to note that Minnesota, while not making special classes compulsory, provides $100 for the training of each mentally defective child. In this way the state itself appropriates $1,500 for each special class of 15 pupils.

Table IV contains a list of cities that have special classes, indicating the total number of pupils enrolled in the public schools, not including high school, the number of special classes, the total number of special-class pupils, the number of special-class teachers, and salaries paid such teachers.

Table IV—Special classes in public schools of cities reporting, and salaries of teachers for the year 1919-1920

CITIES	Pupils in school excluding high schools	Special Classes			Salaries of Teachers	
		Number	Number of pupils	Number of teachers	Minimum	Maximum
Birmingham, Ala.	26,800	2	56	5	.....	.....
Oakland, Cal.	.....	12	192	12	*	*
Los Angeles, Cal.	.....	19	300	19	*	*
San Diego, Cal.	.....	5	70	5	.....	.....
Denver, Colo.	33,353	29	910	30	$1,000	$1,500
Bridgeport, Conn.	20,000	10	200	10	.....	.....
New Haven, Conn.	25,000	7	105	7	700	1,400
Washington, D. C.	50,000	15	269	15	750	1,000
Atlanta, Ga.	26,000	5	75	5	*	*
Chicago, Ill.	258,000	84	1,680	84	900	1,600
East St. Louis, Ill.	9,443	2	35	2	*	*
Indianapolis, Ind.	.....	5	104	6	850	1,200
Burlington, Ia.	3,200	1	7	1	1,100	.....
Des Moines, Ia.	19,738	2	34	1	1,490	.....
Ottumwa, Ia.	4,591	1	25	1	937.50	.....
Kansas City, Kans.	14,164	2	28	2	.....	.....
Topeka, Kans.	6,789	6	110	6	1,155	1,200
Covington, Ky.	6,000	2	45	2	900	.....
Louisville, Ky.	.....	2	.....	2	1,250	.....
Beverley, Mass.	3,400	§	40	3	1,150	.....
Boston, Mass.	110,000	75	1,250	75	876	1,452
Chelsea, Mass.	6,574	3	45	3	700	1,000
Everett, Mass.	7,400	4	50	5	700	1,000
Gloucester, Mass.	3,857	1	12	1	650	900
Haverhill, Mass.	6,150	1	15	1	1,050	.....
New Bedford, Mass.	13,654	5	65	7	1,050	1,150
Newton, Mass.	5,274	3	62	4	950	.....
Salem, Mass.	4,139	4	100	4	850	1,000
Somerville, Mass.	11,300	3	49	3	.....	1,000
Springfield, Mass.	19,809	13	244	.....	.....	.....
Waltham, Mass.	3,000	1	20	2	.....	1,100
Worcester, Mass.	.....	16	437	16	775	1,300
Detroit, Mich.	.....	90	.....	90	†	†
Saginaw, Mich.	4,619	2	29	2	950	.....
Duluth, Minn.	.....	13	232	13	1,000	1,500
Minneapolis, Minn.	45,200	14	210	14	.....	.....
St. Paul, Minn.	27,800	15	205	15	800	1,300
Kansas City, Mo.	42,000	8	118	8	925	1,700
St. Louis, Mo.	93,577	11	471	25	‡	‡
Butte, Mont.	.....	1	16	1	.....	1,800
Omaha, Neb.	26,000	9	140	10	900	1,400
Manchester, N. H.	7,000	3	122	3	625	1,000
Bayonne, N. J.	9,480	6	118	7	800	2,000
East Orange, N. J.	6,246	4	70	4	900	1,500
Elizabeth, N. J.	.....	2	.....	2	.....	1,056
Jersey City, N. J.	38,276	12	152	13	1,100	1,700
Newark, N. J.	69,986	26	400	28	1,000	1,700
Passaic, N. J.	10,070	5	75	5	1,250	1,400
Patterson, N. J.	20,000	7	105	7	1,450	1,500
Plainfield, N. J.	4,300	6	90	6	900	1,700

* Same as salary of regular grade teacher
§ A special school
† Twenty dollars per month above salary of regular grade teacher

Table IV—Special classes in public schools of cities reporting, and salaries of teachers for the year 1919-1920—Concluded

CITIES	Pupils in school excluding high schools	Special Classes			Salaries of Teachers	
		Number	Number of pupils	Number of teachers	Minimum	Maximum
Trenton, N. J.	15,202	14	202	14	700	1,100
Albany, N. Y.	10,000	10	184	.....	900	1,150
Auburn, N. Y.	3,793	4	51	4	750	1,050
Buffalo, N. Y.	52,912	18	.....	18	1,000	1,500
Dunkirk, N. Y.	2,600	2	32	2	850	950
Elmira, N. Y.	4,320	4	60	4	900	1,150
Freeport, N. Y.	1,400	1	16	1	.....	1,100
Haverstraw, N. Y.	700	1	16	1	1,020	.....
Hudson Falls, N. Y.	1,000	1	40	1	850	850
Ithaca, N. Y.	2,083	5	75	5	.....	.....
Jamestown, N. Y.	5,858	3	50	3	720	1,140
Lockport, N. Y.	2,750	2	30	2	850	1,200
Mechanicsville, N. Y.	1,880	1	17	1	950	.....
Medina, N. Y.	800	1	15	1	1,000	1,500
Newark, N. Y.	1,000	1	11	1	.....	.....
New York City	747,369	241	4,129	241	1,040	2,020
N. Tonawanda, N. Y.	1,762	1	15	1	.....	.....
Nyack, N. Y.	.....	2	35	2	1,000	.....
Ogdensburg, N. Y.	1,486	1	14	1	750	.....
Ossining, N. Y.	1,370	1	15	1	1,150	.....
Oswego, N. Y.	2,300	3	45	3	700	750
Port Chester, N. Y.	3,200	1	20	1	1,000	.....
Rochester, N. Y.	30,000	36	550	36	900	1,700
Rome, N. Y.	3,300	2	36	2	800	1,050
Schenectady, N. Y.	.....	4	.....	4	.....	1,300
Solvay, N. Y.	1,250	1	.....	1	900	1,000
Syracuse, N. Y.	18,600	2	27	2	1,300	.....
Troy, N. Y.	6,200	3	46	3	900	1,200
Utica, N. Y.	12,980	9	135	9	850	1,450
Watertown, N. Y.	5,556	4	60	4	650	800
White Plains, N. Y.	3,297	1	24	2	950	1,150
Cincinnati, O.	48,738	20	400	20	950	1,700
Cleveland, O.	99,539	66	1,239	66	700	1,200
Columbus, O.	21,191	9	141	9	1,050	1,650
Dayton, O.	15,860	3	42	3	1,400	1,600
Toledo, O.	27,229	22	325	22	950	1,600
Youngstown, O.	20,961	4	60	4	1,050	1,450
Oklahoma City, Okla.	16,000	1	40	2	.....	.....
Portland, Ore.	36,163	5/8	208	13	800	1,300
Allentown, Pa.	9,905	1	16	1	.....	.....
Harrisburg, Pa.	.....	3	60	3	.....	1,200
Johnstown, Pa.	7,858	8	141	8	.....	1,150
Philadelphia, Pa.	304,415	97	1,987	97	1,000	1,440
Reading, Pa.	13,908	3	49	3	800	950
Scranton, Pa.	20,000	2	30	2	750	1,200
Wilkes Barre, Pa.	11,051	2	.....	2	.....	900
Providence, R. I.	34,261	17	286	17	810	1,025
Charleston, S. C.	.....	1	14	1	.....	.....
Dallas, Tex.	.....	2	24	2	1,300	.....
Houston, Tex.	22,000	2	40	3	1,500	.....
Richmond, Va.	21,833	23	430	23	1,000	1,400
Everett, Wash.	3,950	3	30	3	900	1,560
Seattle, Wash.	39,803	15	312	19	.....	1,800
Milwaukee, Wis.	49,129	6	.....	6	900	1,500

‡ One hundred dollars above salary of regular grade teacher

Special Class Teachers

The first and most important requisite for meeting the needs of the defective children in the public-school system is the selection of properly qualified teachers. As Goddard has said in regard to special-class teachers: "Nowhere are good teachers so valuable and nowhere is the poor teacher such an utter failure and capable of doing so much harm."

Special training in the psychology of mental deficiency is necessary to enable the teacher to appreciate the minds of these children. Association with them, living for a period in schools for the feebleminded, is most desirable. Only the teacher who knows and understands the defective child, who has studied the theoretical side of the problem, who is acquainted with the history of the development of the physiological, the psychological, the pedagogical methods used in instructing defectives, and who has lived and worked with them can be said to be trained for special-class teaching.

Table IV shows that there are 1,292 special-class teachers in these 108 cities. In 53 cities special training is required of teachers doing special-class work. In 33 cities no special training is required. The teachers in these cities are selected because of "interest," "adaptability," "efficiency," etc., from the regular grade teachers.

Twenty-two cities failed to answer this question. It is interesting to note that in Cleveland, Ohio, where no special training is required, 57 of the 66 special-class teachers have had previous training in the field of mental deficiency.

It is obvious that, in order to make highly specialized training worth while, special-class teachers must receive salaries commensurate with the training and service required. The above table shows that $900 is the most frequent minimum salary for special-class teachers, although the range is from $720 to $1,500. Twelve hundred dollars is the most frequent maximum for special-class teachers, although the range is from $750 to $2,200. Sixteen hundred dollars is the most frequent minimum for supervisors of special classes, although the range is from $850 to $5,400. Twenty-five hundred is the most frequent maximum for supervisors of special classes, although the range is from $875 to $5,400. These salaries

have, no doubt, been increased proportionately to the general increase in teachers' salaries that has taken place since 1919.

The greatest outstanding need at present in the matter of teachers is for training courses in normal schools and in universities, with practical work in state institutions for the feebleminded. The demand for specially trained teachers far exceeds the supply. Unfortunately there are only a very few places in the United States at the present time where teachers can receive anything like an adequate training for this work. The state institutions for the feebleminded should be model training schools for special-class teachers, but the present survey of state institutions would lead us to conclude that what they are doing in this direction is almost negligible.

Organization and Equipment of Special Classes

It is generally agreed by all who have given much thought to the subject that the defective child should not be placed in separate classes in the regular schools. Special schools should be established, and in these schools all the defective children within the area served by the school system of the district should be segregated during school hours. In this way the defective child is saved comparison with normal children. He is free from the taunts of others more capable than he and daily associates in play, as well as in work, with those of his kind. The actual school work can be better graded, better organized and systematized. Each teacher can specialize in her own line and far better results can be obtained than when each teacher has to teach every subject in the curriculum.

This study shows that 28 cities, or about 20 per cent of the total number studied, are equipped with special schools or centers, in which buildings are grouped all of the special classes within the city. Such arrangements as transportation and the like are provided by the city. The great advantage of having centered all of the school activities in behalf of the defective children of the city under the direction of highly trained teachers and expert supervisors cannot be overestimated.

It is believed that the size of the class should not exceed 15 pupils per teacher. This study shows that 27 cities had 15

pupils to a class, 14 cities had 16 to a class, 8 cities had 18 pupils to a class, 9 cities had 20 pupils, 2 cities had 25 pupils. The average number of pupils to each class is 16. The minimum per class was 7, the maximum was 41. St. Paul has 41 pupils to a class, and Oklahoma City has 40 to a class.

The importance of distinguishing between the "special class" and the "ungraded class" needs to be stressed. These two types of classes are quite distinct in purpose and method. A child may be backward because of language difficulties, ill health, physical defects, insufficient nourishment, irregular school attendance, or for many other reasons. Proper study and treatment of the causes underlying this backwardness usually serve to return the child to the regular grade. It is for this type of pupils that the ungraded classes are created. On the other hand, the special-class child is a wholly different problem. He is feebleminded, and because of this fact will never under any conditions be able to keep step with the rank and file of school children. The methods necessary to fit him for usefulness in the community are along entirely different lines from those suited to the average "backward" school child. Placing the two together in the same class is an injustice both to the backward and to the feebleminded child. A distinction is made between the special and the ungraded classes in 66 cities, whereas in 35 cities, or 32 per cent of the 108 cities studied, no distinction whatever is made. In 7 cities no answer is made to this question. It is therefore quite likely that many of the special classes represented in this report contain backward children as well as feebleminded.

The organization of these special schools calls for three departments: (1) the kindergarten, in which the children are of the mentality of two, three, or four years; (2) the departmental division, in which the children are of the mentality of five, six, seven, eight, and nine years; and (3) the vocational or trade classes. The subjects that are taught in these various groups are about the same and are adapted to the mentality of the children in the several departments, just as arithmetic is found in the different grades in the regular school.

Selection of Special-Class Pupils: Mental Clinics

One of the purposes of the survey was to ascertain the methods being used by the cities studied in selecting from the schools the pupils for the special class, or, in other words, the criteria being used for the diagnosis of mental deficiency. It is doubtless unnecessary to emphasize the fact that all serious-minded students of mental deficiency deplore the hasty, superficial methods employed by untrained persons, who, armed with a set of Binet tests, plus a few weeks' training in abnormal psychology, pose before school authorities as diagnosticians of mental defect.

Mental tests in the hands of a skilled psychologist who has had adequate laboratory training and ample clinical experience are of immense value in gathering essential data that are to be used in the final diagnosis of the individual child. These tests do not give, however, all of the facts in the case, and sometimes not even the most important facts are thus obtained.

The mental diagnosis of the individual child, the recognition of mental defect as against epilepsy or psychopathic personality or incipient mental disease, is a very complex matter, requiring not only a training in general medicine and in normal psychology, but a highly specialized training in the field of psychiatry.

This investigation shows that 16 of the 108 cities that replied to the questionnaire had no examinations whatever, the children being selected by teachers and principal purely on the basis of school work in the regular grades; that in 54 cities, or about 54 per cent of the total number, special-class teachers, principals, and supervisors gave Binet tests and made diagnoses upon children selected by the grade teachers. With no examination other than these tests, a child is diagnosed as defective or not defective. In 36, or 32 per cent, of the cities studied, psychiatrists or psychologists passed upon the question of mental condition before the child was placed in the special class. In 3 cities trained nurses gave Binet tests.

The following list shows the cities that regard the diagnosis of mental deficiency and other abnormal mental conditions among their school children of sufficient importance either to

employ for this purpose specially trained people—psychiatrists and psychologists—or to utilize existing mental clinics within the city or state:

Birmingham, Ala.	Springfield, Mass.	Nyack, N. Y.
Los Angeles, Cal.	Worcester, Mass.	Ossining, N. Y.
Oakland, Cal.	Detroit, Mich.	Rochester, N. Y.
San Diego, Cal.	St. Paul, Minn.	Schenectady, N. Y.
Denver, Colo.	St. Louis, Mo.	Syracuse, N. Y.
Washington, D. C.	Newark, N. J.	Watertown, N. Y.
Chicago, Ill.	Trenton, N. J.	Cincinnati, Ohio.
Des Moines, Ia.	Albany, N. Y.	Cleveland, Ohio.
Louisville, Ky.	Buffalo, N. Y.	Youngstown, Ohio.
Boston, Mass.	Ithaca, N. Y.	Providence, R. I.
Haverhill, Mass.	Newark, N. Y.	Richmond, Va.
New Bedford, Mass.	New York, N. Y.	Milwaukee, Wis.

In 68 per cent of these 108 cities, children were being placed in special classes for mental defectives without being properly diagnosed by adequately trained experts. As we have indicated above, so many factors enter into the diagnosis of mental deficiency other than the pure question of mental level and intelligence quotient—questions having to do with endocrine conditions, congenital and acquired syphilis, epilepsy, and many other general medical, neurological, and psychiatric problems—that the wholesale diagnosis of mental deficiency by means of mental tests alone would be merely ludicrous were not the fact of its being daily a practice throughout the United States so serious as to warrant grave consideration.

The rapid development of mental clinics in almost all of the larger cities of the country, as well as the growing tendency of state hospitals, state institutions for the feebleminded, and local psychopathic hospitals to create out-patient clinics, promises soon to furnish ample facilities for the careful examination and diagnosis of all mentally defective children in the public schools of the larger cities. School authorities should be urged to utilize these clinics or, in the very large cities, develop their own school clinics with well trained psychiatrists in charge. The present methods of health examination of school children could easily be extended so as to insure and require a careful mental examination of every child obviously retarded in school work. Rural communities and small towns could be served by a traveling mental clinic from the state institution for the feebleminded.

The determination that a child is a proper subject for a special class is of serious consequence to its future welfare. If the decision is correct, it means an opportunity partially to overcome his prodigious handicap. But no greater injustice can be done a child than to class him as feebleminded and at a critical period in his life surround him with feebleminded children when the difficulty is but a temporary retardation in his mental processes which will disappear with the treatment of his physical disabilities and the removal of such other causes of his mental backwardness as may be found.

Training of Special-Class Pupils

As we have indicated in our discussion of the curricula and methods of training feebleminded children in state institutions, the defective child is unable to assimilate the generalized academic training given in the regular grades. The English Commission on The Care and Control of the Feebleminded reports: "Schooling in personal habits was found to be the first step in the education of the defective. Then more and more it was evident that the intelligence was aroused through the hands and eyes working together in making or doing some actual thing, rather than by the secondary and more abstract accomplishments of reading, writing, and arithmetic. This suggested great changes in teaching, and now in the opinion of many the simple occupations of the earliest years of schooling should develop into systematic industrial training, while the scholastic teaching should become entirely subordinate and, indeed, in some cases be entirely discontinued."

Industrial and vocational training is the only means of turning these unfortunate children to practical account. Those subjects which are usually included in the courses of study for the defective classes of the public schools are practically the same as we have mentioned in our discussion of training in institutions for the feebleminded. They include habits of personal cleanliness, sense training, physical training, vocational and industrial training, gardening, academic work, and speech training.

The type of training given in the special classes in the 108 cities studied is as follows:

Types of training	Cities
Manual and industrial training only	8
Regular grade work only	5
Combination of regular grade work, manual, and industrial training	75
No regular scheduled methods of training, leaving question to each individual teacher	17
No reply to this question	3
Total	108

All who have given much thought to defective children emphasize the great value of physical training, yet only 18 out of the 108 cities reported that they were giving any attention to physical training.

Again reverting to the value of industrial training, the replies show the following as to equipment along these lines:

	Cities
Well equipped with facilities for manual and industrial training	50
Fairly well equipped	31
Poorly equipped	10
No equipment	17
Total	108

The classes of 75 per cent of the cities reporting are either well or fairly well equipped for manual and industrial training, while 25 per cent are either poorly equipped or have no equipment at all. These latter might well be included in the "opportunity classes" so aptly referred to by Doctor Porteus when he says, "The children in certain special classes may rightly be regarded as being in an 'opportunity class.' They allow the ordinary grade teacher an opportunity to do better work without them."

The greatest criticism we have to offer from a careful study of the returns of the questionnaire is that school authorities all too frequently see in the special class only a chance to segregate a greater or less number of children from the regular grades; to remove from the wheels of the educational machine a certain amount of grit that disturbs the smoothness of its running gear. Too often it was obvious that there was little or no purpose in view in the training given. Weeks

and months of a defective child's time might be taken up in the making of a basket or the weaving of a rug, or in doing many things that would never lead to self-support. To be sure, these kept the child employed, provided good exhibit material, and relieved the teacher of the necessity of much planning; but as for fitting the child to do some useful thing by means of which he could earn a living, that was a consideration that apparently had received very little thought and attention in the majority of instances.

Supervision of Special-Class Pupils

The part the public-school system through special-class instruction is to play in enabling the state to meet and solve the problem of mental deficiency is to a great extent to be measured by the degree of after-care work and supervision that is to be given these children, not only during the period marked by their years of training in the special classes, but after they have left the school and become a part of the industrial and social life of the community.

We must remember that the mentally defective child will always be a defective. No amount of training will ever make him a skilled workman or ever enable him to direct his affairs with good judgment, common prudence, and reasonable foresight. If, during a few hours of the day, over a few years of childhood, a certain amount of academic and manual training is given him—a little needlework, basketry, weaving, gardening, etc.—and all of a sudden, at the age of 14, 15, or 16, the most dangerous period of his life from a social point of view, he is dumped, unguided, and unsupervised, out into the community to earn a living, can we be surprised later at his shipwreck? In fact, one is prepared to doubt in all seriousness whether it is worth while to have special classes, whether all of the patient and earnest efforts of the several hundred splendid special-class teachers in the long run is going to pay, if there is no organized and systematic follow-up work of the defective pupils.

This study shows that in 26 cities, or 24 per cent of the total number included in the investigation, supervision and after-care work are being given the defective pupils during the period of their attendance in public school. This is done

altogether by the special-class teachers themselves, and is usually a voluntary matter. In a few cities there is an attempt at a definite organization for after-care work. In 82 cities, or 76 per cent of those studied, there is no after-care work of any character. In only 5 cities, Milwaukee, St. Paul, Seattle, Charleston, and Schenectady, was anything like a serious effort being made to keep in touch with the defective children after they had left school and entered employment. Since this questionnaire was sent out, Cincinnati has begun an organization of after-care work of its defective children.

The blame for the failure to meet this important problem of supervision is not to be laid at the door of the special-class teachers. Supervision is certainly not one of their responsibilities. They have all and more than they can do as it is. Some constituted state authority should be charged with the lifelong supervision of all mental defectives who need such care. The public needs to be awakened to the fact that the responsibility for meeting this, the largest problem presented by the defective, cannot be shifted to the shoulders of the special-class teacher.

Conclusion

We are now passing through a period marked by a slow and gradual, but none the less sure and fundamental, change in our whole attitude towards the problem of mental deficiency. The dominant note of the state institution is becoming less and less custodial and more and more medical and educational. There is less and less of the atmosphere of the poorhouse, and more and more that of the hospital and training school. We are thinking more in terms of a sensible, statewide program for handling in some way every mental defective in the state, and for fitting as many as possible for safe supervision on parole in the community, as contrasted with the policy of segregating in some isolated spot a few custodial cases, and leaving the educable defectives to become juvenile delinquents, adult criminals, vagrants, prostitutes, dependents, and paupers.

It was obvious from this study that many states are as yet unaware of this change, or at least fail to appreciate its significance. In some institutions little or no educational work

was being given. In the great majority, such work as was given was without any very definite end in view other than to make some of the children useful around the institution, or to teach a few how to read and to write, to provide exhibit material for visitors and fairs, or to give regular grade work simply because some sort of schooling was supposed to be given.

Each institution seemed to be a unit revolving on its own axis, separate and distinct from all other agencies in the state. The conception of the state institution as the center around which would revolve the entire machinery of the state for the handling of mental deficiency, for intensively training educable defectives and fitting them with trades for useful lives under supervision in the community, for carefully preparing the special-class teachers of the public schools within the state, for conducting mental clinics for these schools, for carrying on research into the causes, distribution, social significance, and treatment of mental deficiency, for educating medical men in the methods of diagnosis, etc., has as yet made little headway. Some of our institutions are fully awake to the importance and possibilities in this direction, but with two or three notable exceptions they have as yet been unable to get under way the machinery for carrying into effect any part of the above program.

The army figures as reported by Colonel Pearce Bailey[1] indicate that there was a ratio of 6.5 defectives for every one thousand men examined. Inasmuch as there were 10,101,506 registrants between the ages of twenty-one and thirty-one years, this ratio would give for the entire number registered 65,650 male mental defectives of the given age period. To quote from Colonel Bailey's report, "If mental deficiency ran uniform among persons of all ages, there would be 353,-210 male defectives in the United States." If there are as many female defectives, we would have above 700,000 mental defectives in this country. Approximately 40,000 are being cared for in state institutions for the feebleminded, or, in other words, about 6 per cent of the entire number.

1 *Mental Deficiency: Its Frequency and Characteristics in the United States as Determined by the Examination of Recruits*, by Pearce Bailey and Roy Haber. MENTAL HYGIENE, Vol. IV, pp. 564-604, July, 1920.

Colonel Bailey, using the army figures, says: "Mental defect is approximately ten times more frequent than drug inebriety or disabling alcoholism, although about one of these terrors the press keeps constantly informing us, and to prevent the other our federal Constitution has been amended; it is three times more frequent than insanity, in provision for which there is a general quickening of interest throughout the country, and for the cure of which at least half a dozen of our states have developed systems of the highest order of merit."

In only a few states has the problem of mental deficiency been considered with any degree of intelligence or foresight by legislators, while it has been almost totally neglected by the federal government.

By far the most outstanding need at the present time, that which transcends all others in importance, is for greatly increased institutional provision. There are still five states that have no separate provision for the mentally defective. The great majority of states are caring for only a few hundred in institutions inadequately equipped for the large problems they have to meet, while in no state are there under way plans sufficiently comprehensive in nature to enable the state to provide institutional care for even those most urgently in need of it.

Adequate institutional provision for all mental defectives is impossible in the present state of public sentiment. Such training as the great majority will receive will be in the public schools. The public schools of the country have not yet taken up this question seriously. In a few cities there are dotted here and there special classes for a few mentally defective children. But there is absolutely no consideration whatever given to the defective children found in the rural and village schools; and yet the army figures showed that two-thirds of the cases of mental deficiency came from rural districts.

In summary, a program adequate for the immediate needs of the situation may be stated as follows: first, greatly increased institutional provision; second, the proper equipment of every institution for the adequate and purposeful training of all children capable of profiting by such training; third,

proper provision for parole under careful supervision of all mental defectives who can be handled satisfactorily in the community; fourth, mental examination by properly equipped experts of all defective children in the public schools (machinery already existing in the state can often be utilized for this purpose); fifth, special-class provision for every defective school child in the community capable of profiting in such classes, these classes to be well equipped along physical training, manual, and industrial lines, and seriously charged with the duty of fitting the defective child for a safe and useful life in society; sixth, after-care — kindly and friendly supervision of all mental defectives.

DECLINE OF ALCOHOL AND DRUGS AS CAUSES OF MENTAL DISEASE

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WHAT has been the effect of the Prohibition Amendment on insanity in New York State? Has the number of alcoholic cases admitted to the state hospitals for mental disease decreased in recent years? Is the number of new cases of drug insanity increasing?

The Bureau of Statistics of the State Hospital Commission has received a statistical card for each patient admitted to the thirteen civil state hospitals for mental diseases since October 1, 1908. Among other things this card contains data concerning the form and causes of the mental disease of the patient, and a statement of his habits with respect to the use of alcohol and drugs. The patients admitted for the first time to any hospital for the treatment of mental disease are called *first admissions,* and those admitted who have previously been patients in institutions for mental cases are called *readmissions.* As the annual rate of first admissions shows better than any other data the incidence of mental disease, the readmissions are not included in this study.

During the twelve fiscal years from October 1, 1908 to June 30, 1920, the civil state hospitals received 72,699 first admissions, of which 38,147 were males and 34,552 were females. The total first admissions of each year and the number of cases of alcoholic and drug insanity among them are shown in Table 1.

Referring to Table 1, we note that the number of first admissions increased each year from 1909 to 1914. In 1915 there was a slight decrease. In 1916 the fiscal year was changed so that it ended on June 30, instead of September 30; the 1916 statistics therefore cover but 9 months. In 1917 a remarkable increase in first admissions took place, due probably to the great emotional disturbances accompanying the entrance of the United States into the World War. In 1918 and in 1919 a slight drop in the number of first admissions occurred and in 1920 the decline was more marked.

TABLE 1. ALCOHOLIC AND DRUG CASES AMONG FIRST ADMISSIONS TO THE CIVIL STATE HOSPITALS FOR THE INSANE, 1909-1920

YEAR	TOTAL FIRST ADMISSIONS			ALCOHOLIC PSYCHOSES						DRUG PSYCHOSES					
				NUMBER			PER CENT			NUMBER			PER CENT		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
1909.....	2,780	2,442	5,222	433	128	561	15.6	5.3	10.8	8	16	24	0.3	0.7	0.5
1910.....	2,957	2,607	5,564	452	131	583	15.3	5.0	10.5	10	12	22	0.3	0.5	0.4
1911.....	3,013	2,687	5,700	444	147	591	14.7	5.5	10.4	13	8	21	0.4	0.3	0.4
1912.....	3,010	2,732	5,742	434	131	565	14.4	4.8	9.8	7	11	18	0.2	0.4	0.3
1913.....	3,191	2,870	6,061	438	134	572	13.7	4.7	9.4	10	11	21	0.3	0.4	0.3
1914.....	3,338	2,927	6,265	348	116	464	10.4	3.6	7.4	19	17	36	0.6	0.6	0.6
1915.....	3,260	2,944	6,204	255	90	345	7.8	3.1	5.6	12	12	24	0.4	0.4	0.4
1916 (9 mos.) .	2,572	2,331	4,903	215	82	297	8.4	3.5	6.1	6	8	14	0.2	0.3	0.3
1917.....	3,605	3,272	6,877	437	157	594	12.1	4.8	8.6	3	5	8	0.1	0.2	0.1
1918.....	3,530	3,267	6,797	257	97	354	7.3	3.0	5.2	7	12	19	0.2	0.4	0.3
1919.....	3,527	3,264	6,791	204	65	269	5.8	2.0	4.0	5	11	16	0.1	0.3	0.2
1920.....	3,364	3,209	6,573	90	32	122	2.7	1.0	1.9	3	8	11	0.1	0.2	0.2
Total.....	38,147	34,552	72,699	4,007	1,310	5,317	10.5	3.8	7.3	103	131	234	0.3	0.4	0.3

The completion of the Federal census of 1920 enables us to compute for the several years the rate of first admissions per 100,000 of the general population of the state. Such rates are shown in Table 2.

TABLE 2. RATE PER 100,000 OF GENERAL POPULATION OF ALL FIRST ADMISSIONS TO THE CIVIL STATE HOSPITALS FOR THE INSANE, 1909-1920

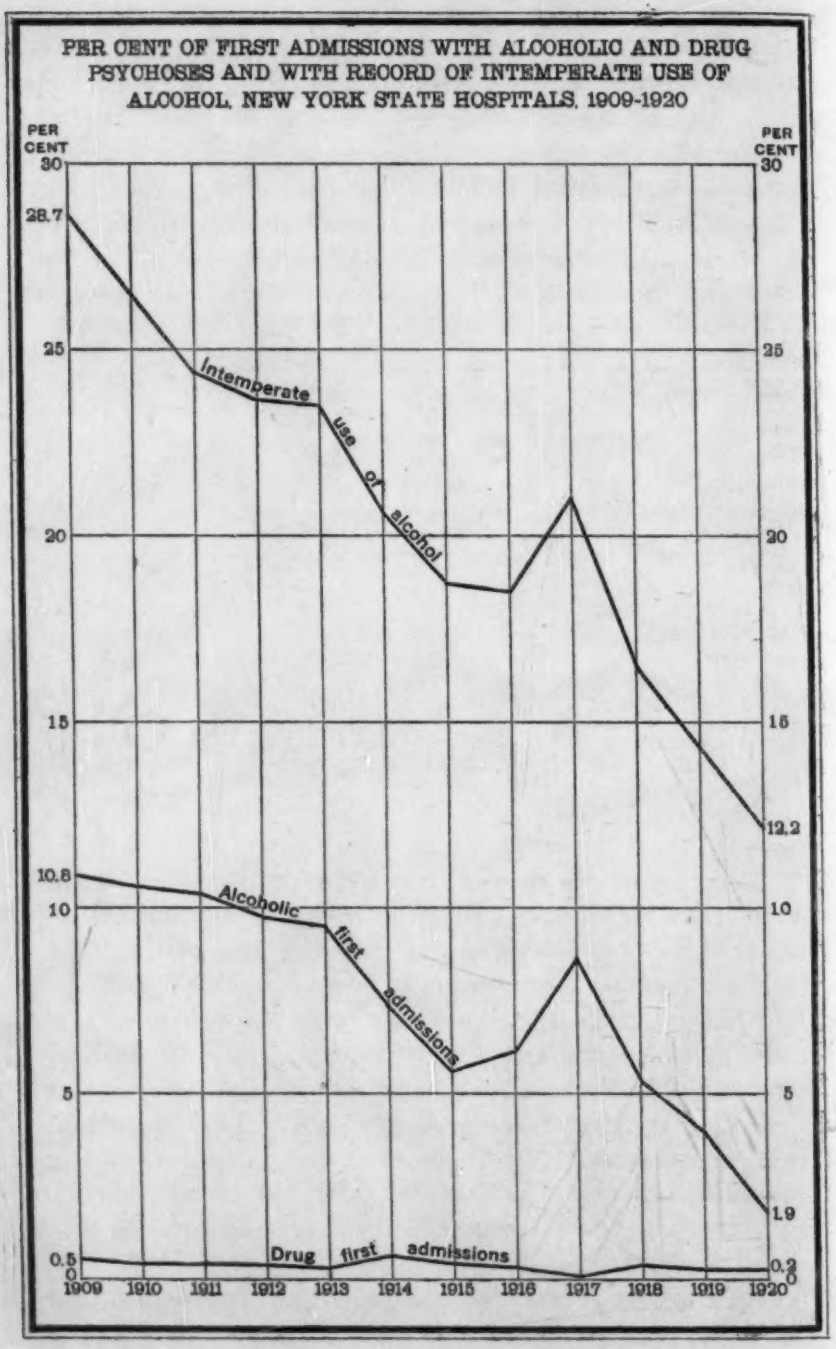
Year	Total first admissions	Rate per 100,000 of general population
1909	5222	58.6
1910	5564	61.0
1911	5700	61.8
1912	5742	61.5
1913	6061	64.1
1914	6265	65.4
1915	6204	64.0
1916 (9 mos.)	4903	66.5*
1917	6877	69.0
1918	6797	67.3
1919	6791	66.3
1920	6573	63.3

* Reduced to yearly basis.

The decline in the rate of first admissions during the past year is very significant. From it we catch a gleam of hope that the heavy burden of mental diseases now resting on the people of the state may gradually become lighter.

The excessive use of alcohol may cause the forms of mental disease known as the alcoholic psychoses or be a precipitating factor of other forms of mental disease. The alcoholic psychoses form a distinct group in the standard classification of mental diseases and the diagnosis of the cases does not present great difficulty. It may be safely assumed, therefore, that practically the same standards have been applied in filling out the statistical cards from year to year.

Table 1 gives, by sex, the number and percentage of cases of alcoholic psychoses among first admissions to the civil state hospitals each year from 1909 to 1920. The total alcoholic


PER CENT OF FIRST ADMISSIONS WITH ALCOHOLIC AND DRUG PSYCHOSES AND WITH RECORD OF INTEMPERATE USE OF ALCOHOL, NEW YORK STATE HOSPITALS, 1909-1920
PER CENT
30
28.7
25
20
15
10.8
10
5
0.5
0
Intemperate use of alcohol
Alcoholic first admissions
Drug first admissions
12.2
1.9
0.2
0
1909
1910
1911
1912
1913
1914
1915
1916
1917
1918
1919
1920

first admissions during the twelve fiscal years were 5,317, of which 4,007 were males and 1,310, females. During the five fiscal years, 1909 to 1913, inclusive, the annual number of alcoholic cases averaged 574 and varied but little. In 1914 there was a marked drop in the number and this was followed by another drop in 1915. In 1917 a marked increase occurred, but this was followed by a rapid decline until, in 1920, the total alcoholic first admissions numbered only 122. The percentage of alcoholic cases among first admissions dropped from 10.8 in 1909 to 1.9 in 1920.

The annual rates of alcoholic first admissions per 100,000 of the general population are shown in Table 3.

TABLE 3. RATE OF ALCOHOLIC FIRST ADMISSIONS TO THE CIVIL STATE HOSPITALS FOR THE INSANE PER 100,000 OF THE GENERAL POPULATION OF THE STATE, 1909-1920

Year	Number	Rate per 100,000 of general population
1909	561	6.3
1910	583	6.4
1911	591	6.4
1912	565	6.0
1913	572	6.0
1914	464	4.8
1915	345	3.6
1916	297	4.0*
1917	594	6.0
1918	354	3.5
1919	269	2.6
1920	122	1.2

* Reduced to yearly basis.

It will be noted that the rate of alcoholic first admissions per 100,000 of the general population declined from 6.4 in 1910 to 1.2 in 1920.

INTEMPERATE USE OF ALCOHOL

If the facts concerning the decrease in alcoholic mental disease stood alone, they might be interpreted as being due to changes in diagnosis rather than to changes in the use or influ-

ence of alcohol. Additional light is thrown on the matter by the record of the intemperate use of alcohol by first admissions prior to the onset of the mental disease. The facts relative to such use are shown in Table 4.

TABLE 4. INTEMPERATE USERS OF ALCOHOL AMONG FIRST ADMISSIONS, 1909-1920

Fiscal year ending	Number			Per cent of total first admissions		
	Males	Females	Total	Males	Females	Total
1909....	1,229	369	1,598	44.2	15.1	28.7
1910....	1,684*	488*	2,172*	56.9	28.7	38.1
1911....	1,082	302	1,384	35.9	11.2	24.3
1912....	1,097	273	1,370	36.5	10.0	23.8
1913....	1,103	318	1,421	34.6	11.1	23.5
1914....	1,027	258	1,285	30.8	8.8	20.5
1915....	939	225	1,164	28.8	7.5	18.7
1916....	725	182	907	28.2	7.8	18.5
1917....	1,152	300	1,452	32.0	9.2	21.1
1918....	851	253	1,104	24.1	7.7	16.2
1919....	804	161	965	22.8	4.9	14.2
1920....	684	119	803	20.3	3.7	12.2
	12,377	3,248	15,625	32.5	9.4	21.4

* Includes moderate drinkers.

It appears that of the first admissions of 1909, 44.2 per cent of the males and 15.1 per cent of the females were intemperate users of alcohol. In 1910 the moderate drinkers were included with the intemperate in the tabulation, but for subsequent periods the figures show a marked decline in the percentage of intemperate users, until, in 1920, only 20.3 per cent of the males and 3.7 per cent of the females were reported in the intemperate group.

In considering these facts in connection with the Prohibtion Amendment it should be remembered that the amendment was in force for only five and one-half months of the fiscal year that ended on June 30, 1920. Of the 122 new cases of alcoholic mental disease admitted to the civil state hospitals during the year, 75 reached the hospitals before January 16, 1920, and 47 after that date. As nearly all forms of alcoholic mental

disease result from long continued and excessive use of alcohol, it would be expected that some cases would develop after the public sale of intoxicating liquors ceased. The great reduction in the rate of admissions of new alcoholic cases since the amendment went into effect indicates that excessive drinking has been much lessened, if not entirely stopped.

In this connection it should be remembered that for several years prior to the passage of the Prohibition Amendment there had been a gradual decline in excessive drinking and that during the greater part of the war traffic in distilled liquors was forbidden.

Mental Disease Due to Drugs

It was feared by many that the discontinuance of the public sale of alcohol as a beverage would result in increased indulgence in the use of narcotic drugs and that the number of cases of mental disease due to such drugs would greatly increase. By referring to Table 1, we find that the drug cases among first admissions have declined rather than increased during the past year.

Drugs have never been prominent among the causes of insanity in this state. The highest number of drug first admissions to the civil state hospitals recorded in any one of the past twelve years was 36, in 1914. These constituted about 0.6 per cent of the total first admissions. Since 1914 the annual number of drug cases has declined, there being but 11, or less than 0.2 per cent of all first admissions, in 1920.

Conclusions

1. The annual rate of the incidence of mental disease in New York State has decreased since 1917.
2. The annual rate of admissions of new cases of alcoholic mental disease to the civil state hospitals has greatly declined in recent years and reached its lowest point in 1920.
3. The percentage of first admissions with a history of intemperate use of alcohol has declined since 1917 and was lowest in 1920.
4. The annual rate of new cases of drug insanity admitted to the civil state hospitals has declined in recent years.

AN EXPERIMENT IN LIBRARY WORK IN A HOSPITAL FOR MENTAL DISEASE

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A. L. A. Librarian, St. Elizabeths Hospital, Washington

MANY know of the work accomplished by the American Library Association during the war—of the camp libraries that came into existence almost simultaneously with the erection of the various military cantonments whose doors welcomed eager readers from early morning until "taps" were sounded; of the books on the transports that cheered our men not only on their way to battle, but also on the homeward journey, helping to speed away what otherwise might have been dull hours of waiting; of the A. L. A. Headquarters at Paris, which was the center of our library activities abroad, serving men not only at the front, but *en repos*.

They may know, also, of an important phase of this work that was undertaken early in 1918, to serve men, weak in body and spirit, whose health had been broken either before entering upon their duties on the firing line or as a result of wounds and injuries received in battle. They can picture the hospital librarian wheeling her book cart through the wards of her hospital to the bedside of each patient able to read, cheering him on his road to recovery with her "wares," which consisted, not only of books, magazines, papers, pictures, and scrapbooks, but also of a word of cheer or a story to help brighten the day. Nor did she leave the ward without paying her respects to the medical officer in charge, who, perhaps, desired books of a scientific or recreational nature, and a glance at the morning paper; or the nurse, who wanted a novel or a magazine to read in her spare moments; or the faithful corpsman, who, when his duties were completed, liked to improve his time by reading or studying books relating to his vocation instead of sitting at his desk with arms folded. Patients, doctors, nurses, and corpsmen were served alike by the "Book Sister," as she was invariably called.

Hospital librarians were sent to general hospitals, which cared for the ordinary medical and surgical cases of each cantonment, to special hospitals for the tuberculous, to hospitals

that served those blinded in battle, and to orthopedic hospitals for surgical cases that required prolonged treatment of a nature too specialized to be treated in the general hospitals. It may not be so generally appreciated, however, to what extent book service was carried on by the American Library Association in hospitals that specialized in nervous and mental diseases. Hospital librarians were there also to serve perhaps the most unfortunate of all our service men—those soldiers, sailors, and marines who were broken mentally as well as physically. Librarians were not only assigned to hospitals caring for acute psychopathic patients, but were on duty also in one of the largest institutions in the country that cares for those most severely afflicted—the insane. St. Elizabeths Hospital, the 3,700-bed Government Hospital for the Insane, at Washington, D. C., received, during the war, such nervous and mental cases among our service men as required prolonged and special treatment, and to this institution many men were transferred from camp hospitals. Soon after their arrival, a call came from A. L. A. service, and I was fortunate enough to be assigned to duty there. A few of my personal experiences may be worth relating to emphasize the value of book service for the mentally ill, not only from a recreational, but also from a therapeutic standpoint.

A word is necessary first, however, concerning library work in psychopathic hospitals before the war. Library work among the mentally diseased had already been carried on successfully at McLean Hospital, Waverley, Massachusetts, by Miss E. Kathleen Jones, who was for several years librarian of that institution and extremely interested and efficient in that field. Good results had been obtained also by Miss Miriam Carey and Miss Julia Robinson, of Minnesota and Iowa respectively, who have long been interested in the development of institutional library work. In spite of such work as this, it was the war that really opened the eyes of librarians to what could be done for the mentally disabled.

Hospital librarians on duty in general hospitals counted among their patrons those patients who were assigned to the neuropsychiatric wards on account of acute mental illness. The interest in such patients—assumed by the librarians in spite of many difficulties, for both doctors and nurses were at

first extremely skeptical as to the value of book service in their wards—and the results finally obtained, due principally to the splendid resources offered those librarians by the association, paved the way for a still further extension of the work. An experience of one of the hospital librarians, stationed in a Southern hospital, will illustrate this point. On her first visit to the neuropsychiatric wards, she was greeted not at all cordially by the medical officer and nurse in charge. Both advised her that their patients would not care to read or could not read, and that it was useless, according to their opinion, for her even to "make rounds" on those particular wards. Such rebukes, however, did not daunt her enthusiasm. She was determined to serve all alike and to give those patients a fair trial, at least. After obtaining a reluctant permission from the medical officer to visit his wards, she started forth. "Perhaps I am foolhardy, after all," was her thought as she entered the ward and was greeted by blank faces and no response to her questioning. One after another scorned her "wares," but just as she was about to leave, a call came from a patient nearby, who requested a book on salesmanship. That "broke the ice," and others began to show a willingness to accept magazines, pictures, and scrapbooks. A start, at least, had been made.

A second visit to the ward revealed the fact that the lad who had requested the book on salesmanship had actually been a salesman and wished to continue his study of the subject. From that time on, he, as well as his companions, never allowed the librarian to pass by without requesting books or other material.

On one of her visits to the same ward, a patient who had asked her to bring him the last number of the *Review of Reviews* called her back a second time, asking her to bring him also a box of gingersnaps and some cigarettes. Realizing that gingersnaps and cigarettes might help in gaining the confidence of patients, she "delivered the goods"—books, gingersnaps and cigarettes—the same afternoon. After that, whenever she approached that particular ward, she was greeted by her friend, who smilingly offered to help her distribute her books and magazines. He seemed to take a great deal of pleasure, also, in informing her of the reading capacity of his

Book delivery at Fort Oglethorpe, Georgia

Reading room, St. Elizabeths Hospital, Washington, D. C.

associates. After spending several months in that ward, he recovered sufficiently to be discharged and was able to accept a position in a small Mississippi town, evidently located far from the resources of a library. But he did not forget the hospital library, as the following extract from a letter received by the hospital librarian will testify:

> "You know I sometimes wish I were a soldier yet. As I stated before, I shall never forget Camp Greenleaf and the nice librarian lady . . . Don't suppose you could afford to send me any books now as I'm a civilian, but would like to read *When a Man's a Man.*"

Gradually the work among the nervous and mental patients increased until it equalled in magnitude that of the other hospital wards. Medical officers and nurses, once skeptical as to the value of this service, now were as eager as the patients to welcome the librarian to their wards, and more than once expressed the opinion that books actually were of therapeutic as well as of recreational value to their patients. Those of us who had experience with the nervous and mental patients in camp hospitals, and those of us who continued to work among them long enough to see results, realized that a new field of work was before us. Doors were opened to us which had never been open before, and possibilities for service presented to us that we had not even suspected.

April 1, 1919, found me journeying toward St. Elizabeths Hospital. As I walked through the beautiful grounds that balmy spring morning, receiving on every hand cheerful greetings from patients able to stroll about at their pleasure, I could scarcely imagine myself in or near an insane hospital. I wondered if the hospital authorities had ever provided a library for the use of patients who, instead of restlessly wandering about, might wish to spend their leisure time in reading. Surely, among 3,700 patients, there must be many readers. When I reached the "Center Building," so-called because it was once used as an administration building for the hospital group, my curiosity was satisfied, for I was directed to the library on the first floor of that building. Two rooms, one used as a stack room and the other for storage purposes, were filled to overflowing with books. Dignified volumes of ancient origin stood side by side on the shelves

with their younger companions, whose overwhelming popularity was evidenced by their tattered and torn condition. Were these books actually read or maliciously destroyed? I was soon to see.

The library was opened two mornings a week for the use of the patients, being supervised by one of the women physicians, who was obliged to leave her own important duties for the time in order to serve as best she could the eager throng seeking books. But it was better to have such a library than no library at all and better to have such service than no service at all. The hospital authorities, handicapped by increased expenses that had to be met with limited funds, were unable to set aside a library budget sufficient to insure upkeep of the library. Owing, however, to the transfer of many military patients to the institution, the reading public had increased materially and must be served, and the hospital authorities were very glad to be relieved by the A. L. A. in the matter of book service, even if only temporarily. A nucleus of a library was there and a chance for the A. L. A. to give real service.

"Library Day" rolled around soon after my arrival. As soon as the doors were opened, in came soldiers, sailors, and marines who had served in the World War, those on parole coming at their leisure, the others being accompanied by nurses or attendants. Army and navy medical officers and their detachment men, stationed at the hospital to care for the 1,500 or more service men who were patients there, came also, all with one desire—"something to read." Civilian doctors, members of the hospital staff, as well as their wives and children, and hospital employees wished to be served too, for they were far distant from the resources of a public library. An occasional Civil or Spanish-American War veteran wandered in, for St. Elizabeths Hospital cares for the service men not only of this, but of former wars. Former government officials, and others, citizens of the District of Columbia, including men and women of many nationalities are, also, patients of this hospital. Thus the library must serve not only service men, but the entire hospital community, a veritable city in itself.

It was plain to be seen that those most eager and those best able to read could come to the library. The first and most

essential task, then, was to provide a central reading room for those who desired to free themselves for the time being from the hospital atmosphere. In a few weeks the storage room was transformed. The old and worn-out volumes were replaced by new and attractive ones. The room, though located on the north side of the house and lacking the cheerfulness of sunshine, was brightened by the addition of rugs, plants, flowers, and pictures, and furnished with reading tables and comfortable chairs. Patients, doctors, nurses, detachment men, and other employees alike enjoyed this recreational center, which was open morning and afternoon daily, except Sunday. There they came and read or chatted at their leisure. Books were available for those who wanted to concentrate on them, magazines and scrapbooks for those who wished such material, and newspapers for those who desired to keep in touch daily with the outside world. The librarian's desk was placed in a corner of the stock room, which adjoined the reading room; thus she was near, yet removed from the notice of readers who might not care to be watched. Personal attention was given those who desired aid in the selection of books, and the librarian was never too busy to chat with her patrons.

The next step was to reach patients who were too ill to come to the reading room even with their nurses. Judging from the requests brought in from the wards by nurses, many patients at times were not infrequently able to enjoy a magazine, a scrapbook, or even a book. The matter was certainly worth investigation. Leaving an assistant in charge of the reading room after the work there was well organized, I made a tour of the wards in order to find patients who were able to read. Realizing that most patients who were unable to reach the library probably would be in no condition to concentrate on books, I took magazines and scrapbooks. Sufficient time was allowed to approach each patient and to give him individual attention.

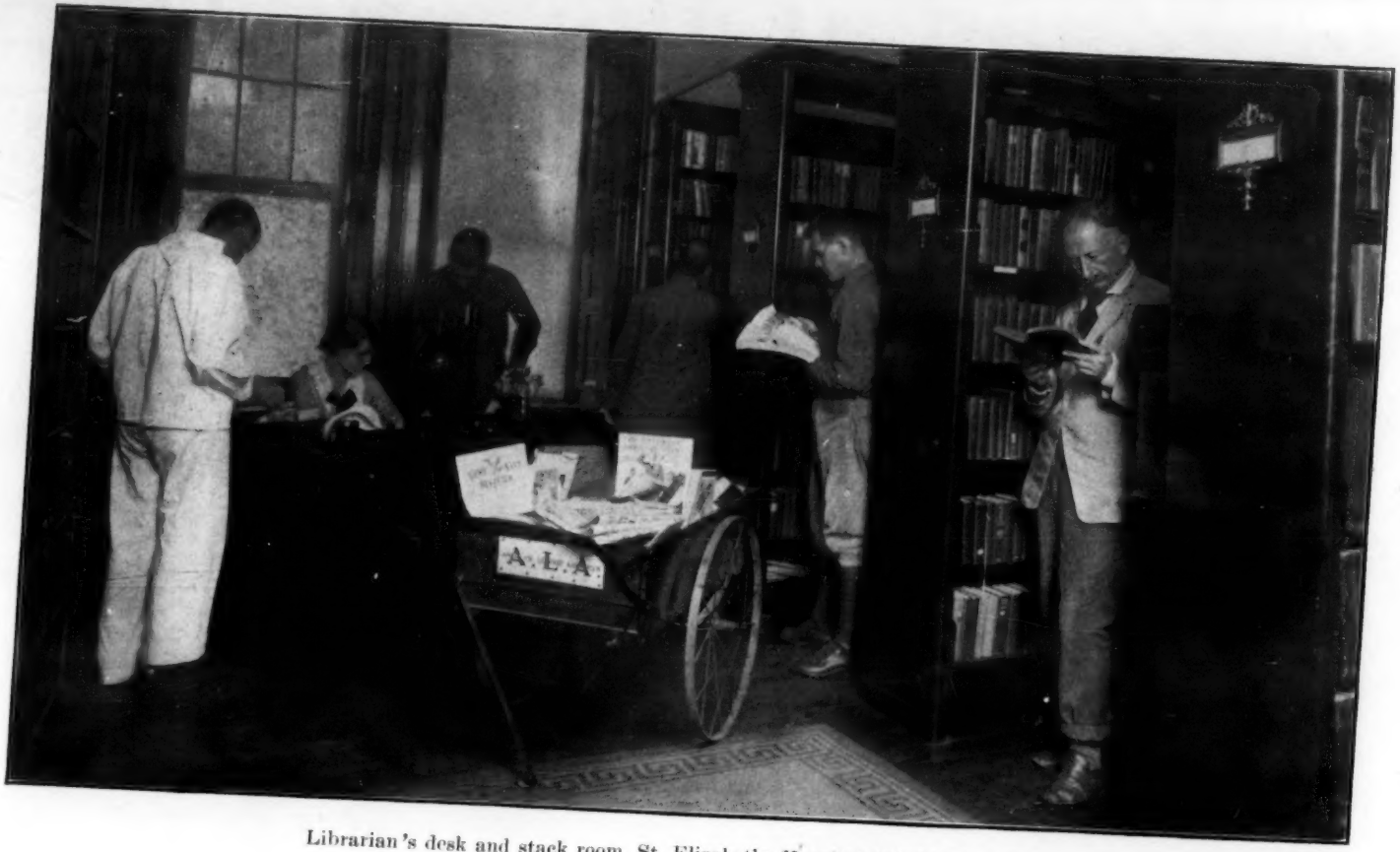
I found, after making a survey of the wards, that many of the patients were not satisfied with magazines and scrapbooks alone, but desired books. A soldier in one of the wards for epileptics, when asked what kind of reading matter he wished, replied in gruff tones that he wanted nothing in the world but

his discharge papers. His head was buried in his lap, but just as I was about to leave he raised it, discovering for the first time that it was not a nurse who had addressed him, but as he thought, "a lady from Alabama." It happened that his home was in Alabama, so he immediately became interested in talking with me. After I had explained the meaning and purpose of the A. L. A., he produced from his pocket a notebook, asking me to observe what he had been doing to amuse himself during his leisure hours. The pages were filled with designs and lettering of various kinds. I discovered during my conversation with him that his pre-war occupation had been that of draftsman. He was surprised to learn that the libarary contained books on this subject, and when he received one, that same afternoon, I am sure he did not have much time to fret about his discharge. After studying that special book for over a week, he requested more, thus occupying his time advantageously. It was much pleasanter, upon entering his ward, to see him reading rather than with his head buried in his lap.

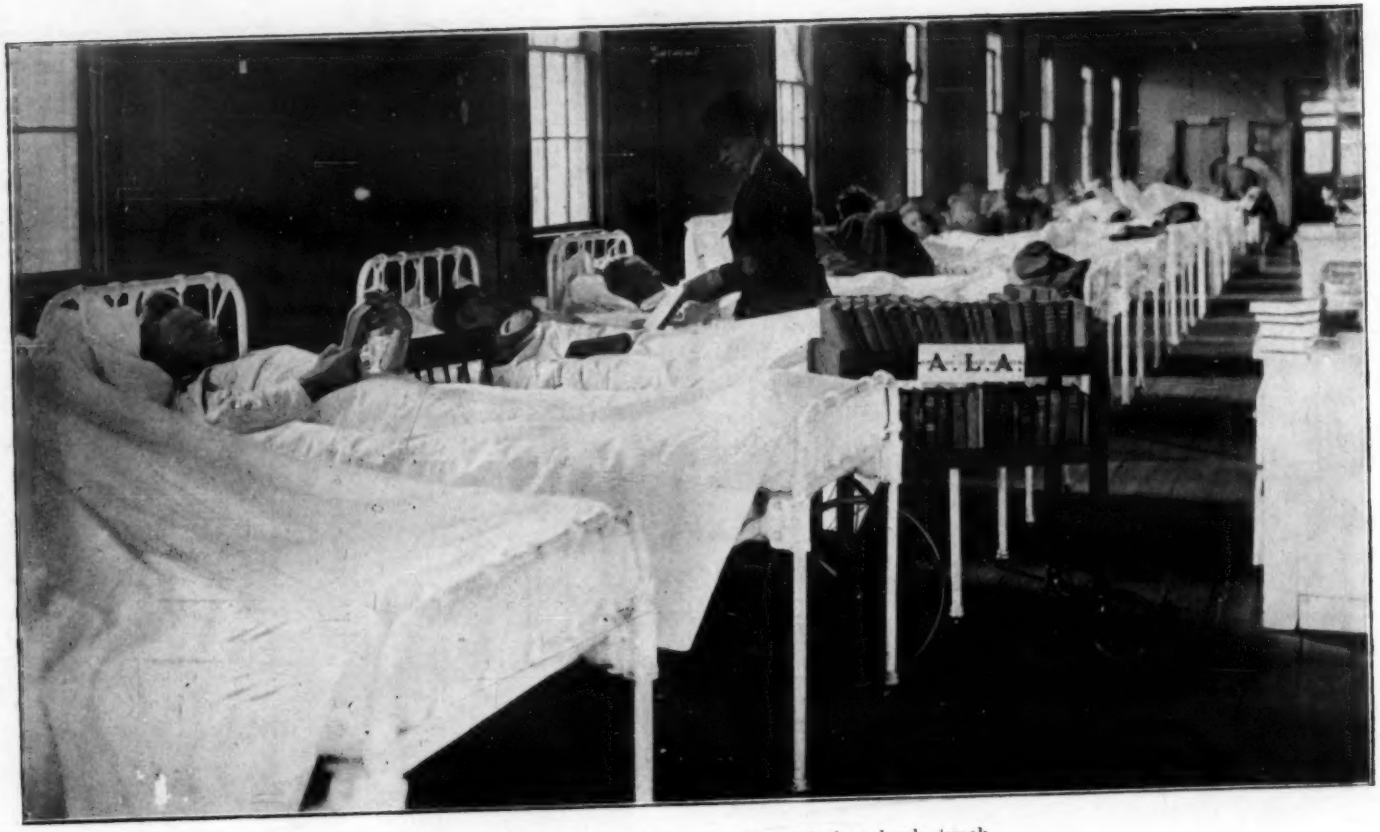
It was soon discovered that ward visiting equaled in value the service rendered in the reading room. A schedule was made so that all wards might be visited once or twice weekly. The disturbed patients were not neglected, for among them were found occasional patients who were glad to receive magazines or scrapbooks; the material left with them was of such a nature that it would be no great loss, if destroyed.

Attendants always accompanied me through the "disturbed" wards and were very kind in aiding me by introducing to me those patients who were able to read or look at pictures. Scrapbooks proved to be of inestimable value in all wards. Home papers were asked for continually, and were supplied to patients who did not care to have any other reading matter.

It was the belief of the medical officers that in the diversion provided the patients, both those who used the reading room and those served in the wards, the library performed a not unimportant therapeutic function. In addition to the reading itself, in the library workroom nearby work of various kinds was done by patients who time and again expressed a desire to have something to do. They sorted magazines, which came



Librarian's desk and stack room, St. Elizabeths Hospital, Washington, D. C.



Hospital librarian making rounds with her book truck

to the library in great numbers weekly, made scrapbooks, picked flowers for the reading room, and accomplished numerous other tasks, thus pleasantly occupying their leisure time and aiding the librarian. Occasionally one would be discovered who was able to use a typewriter. One patient enjoyed wheeling the book cart back and forth from the library to the wards and serving as a page. He formerly had delivered papers on the hospital grounds and was thus familiar with all the hospital wards and knew the patients in them. Needless to say he was of great value to the librarian. His condition constantly improved and it is possible that the diversion and the renewed sense of responsibility had something to do with this.

Besides being of recreative and therapeutic value, the library served still another purpose. By supplying vocational books on every trade and profession that were of interest, not only to the army and navy detachment men who soon expected their discharge, but also to patients who wished additional information concerning their former occupations, and by furnishing books of interest to foreigners who wanted to learn the English language, the library performed a special educational function. Greatly to my surprise, patients were as much, if not more, interested in the vocational books than the detachment men. One patient eagerly devoured books and government publications on bee-keeping; another asked for books on sheet-metal work; still another requested a book on veterinary pathology. It was remarkable to note that earnest reading was constantly done along such lines.

From such a limited experience it would not be safe to draw too many conclusions about the most suitable material for library work in hospitals for mental disease, but from my observations both in the neuropsychiatric wards of general hospitals and at St. Elizabeths, I should say that as far as fiction is concerned O. Henry, Zane Grey, Bower, Bindloss, Beach, London, Twain, and Oppenheim were as popular there as elsewhere. Calls for non-fiction were varied. A list of material selected at random from my notebook will show the variety and scope of the requests. Plutarch's *Lives,* Shakespeare's *Julius Caesar* and *Richard III,* Homer's *Iliad,* and other classics were called for. Biographies of Washington,

Hospital librarian making rounds with her book truck

Lincoln, Napoleon, Roosevelt, Longfellow, and Whittier were enjoyed. Histories were extensively read, one particular reader devouring volume after volume of Macauley's *History of England.* Books in the foreign languages had a wide circulation and included the following: Czecho-Slovak, Polish, Spanish, French, Italian, Bohemian, Roumanian, and Russian, for all nationalities must be served. From one ward came the following requests for reading material in one day:

NON-FICTION	
Book on the fourth dimension	Italian grammar
Book on British costumes	Photography
Biology	Salesmanship
Tailoring trade	History of the Republican Party
Spanish grammar	Greek mythology
Gas engines	FICTION
Blue-print making	*Tarzan of the Apes*
	Thelma

It is interesting to note the percentage of non-fiction.

The following note from one of the patients confined in the prison wards speaks for itself:

> "*Miss Librarian:*
>
> "I wish to thank you very much for the patience you show in selecting the books which are sent to this hall, and as we send for quite a lot, I am sure it is very trying to look up all of these; but as we inmates have the misfortune to be confined behind walls, reading is about the only diversion we can occupy our minds with. So we look forward to getting these books with great enjoyment. So whatever trouble you go to in selecting these books, you can feel that you are doing a very great favor to many unfortunates, and that it is sincerely appreciated,
>
> Sincerely yours,
>
> _____"

If special training is needed to conduct an organization that gives mental food to the well, how much more important it is that a similar organization that gives mental food to the sick, especially the sick in mind, shall be in the hands of one who has been especially trained for the work.

PATIENTS WITH MENTAL DISEASE, MENTAL DEFECT, EPILEPSY, ALCOHOLISM AND DRUG ADDICTION IN INSTITUTIONS IN THE UNITED STATES, JANUARY 1, 1920

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Statistician, New York State Hospital Commission

EDITH M. FURBUSH
Statistician, The National Committee for Mental Hygiene

WITH the coöperation of institutions in the several states, the National Committee for Mental Hygiene presents its third census of patients with mental disease, mental defect, epilepsy, alcoholism and drug addiction. The former enumerations were made on January 1, 1917, and January 1, 1918. The purpose of this census is threefold: first, to ascertain the total number of such patients receiving treatment on January 1, 1920; second, to furnish a basis for comparison with the 1920 census of the general population of the country; and third, to show the changes that have taken place in institutional care since 1910.

Although most of the institutions caring for the classes enumerated generously coöperated by promptly filling out the schedules sent them by the committee, the most diligent effort failed to elicit the desired data from a few institutions. In these cases the patient population was estimated from data available in previous reports. The possible errors in these estimates are insignificant in relation to the magnitude of the totals in the several states.

Data for this study were obtained from Public Health Service hospitals in addition to the state, city and county, and private institutions included in previous studies. The institutions represented are classified as follows:

1. Number of institutions	625
a. Public	388
b. Private	237

2. Public institutions for mental diseases
   a. State hospitals 156
   b. Federal hospitals 2
   c. County and city institutions (not including those for temporary care) 125
   d. Institutions for temporary care 21
3. State institutions for mental defectives.... 32
4. State institutions for mental defectives and epileptics. 11
5. State institutions for epileptics 10
6. City institutions for mental defectives..... 1
7. Private institutions
   a. Having mentally diseased patients only 60
   b. Having mental defectives only..... 27
   c. Having epileptics only 6
   d. Having mental defectives and epileptics only 19
   e. Having inebriates (alcoholics and drug addicts) only 12
   f. Having more than one of these classes (excluding "d" above) 113
8. Public Health Service hospitals 30

No schedules were sent to almshouses or penal or reformatory institutions.

This census differs from those taken in 1917 and 1918 in the care taken to exclude all patients on parole or otherwise absent from the institutions. The 1917 and 1918 censuses included all patients on the books of the hospitals whether temporarily absent or not. In view of the rapid development of the parole system in several states during the past five years, the paroles now constitute a disturbing factor in making statistical comparisons in different periods. In 1910, when the last federal census of the insane and feebleminded was taken, paroles were so few that they were considered a negligible factor.

Patients With Mental Disease

(See Table I, page 156.)

On January 1, 1920, there were 232,680 patients with mental disease actually in institutions in the United States. Of these,

200,109 were in state hospitals, 21,584 in county or city institutions, 1,040 in institutions for temporary care, 709 in Public Health Service hospitals, and 9,238 in private hospitals. In 1918 the total number of patients with mental disease reported on the books of the several institutions was 239,820. Of this number 15,863 were reported as on parole from the state hospitals on the day of enumeration. The number on parole from private institutions was not obtained, but it is believed to be very small. The number of patients actually in the institutions on January 1, 1918, was approximately 223,957, or 8,723 less than the number on January 1, 1920.

In all but 8 of the states the patients in public institutions are found exclusively in state hospitals. Wisconsin is the only state in which a majority of these patients is in county institutions. In 12 states there are institutions for the temporary care of mental cases, including psychopathic hospitals, psychopathic wards in general hospitals, and detention hospitals. In 32 states there are private institutions for mental patients, but in only 3 does the number thus cared for reach 1,000. In 15 states the number is less than 100. In Maryland the percentage of patients cared for in private institutions is 26.6. In all of the other states the percentage is much lower.

Sex of Patients with Mental Disease

Of the 232,680 patients with mental disease in institutions on January 1, 1920, 121,031 were males and 111,649, females. The percentages were 52.0 and 48.0 respectively. The number of males to each 100 females was 108.4. In 1918 the number was 110.6; in 1910, 110.8; in 1904, 109.6; in 1890, 107.4; and in 1880, 101.6.

With the marked decline in alcoholic psychoses and the gradual reduction of the syphilitic psychoses it is probable that the excess of males in the hospitals for mental diseases and among admissions to them will ultimately disappear.

The sex distribution of the mental patients in the several states varies more widely than that of the general population. In most of the Eastern and Southern states the women patients outnumber the men, while in the Western states the

men patients are in the majority. The ratios in 1920 and in 1918 in some of the more populous states were:

	Number of male patients to each 100 female patients	
	1918	1920
California	142.3	133.5
Illinois	116.5	109.9
Massachusetts	98.1	94.4
Michigan	118.0	114.6
New York	90.3	90.5
Ohio	113.4	113.1
Pennsylvania	114.5	112.3
Wisconsin	125.5	124.1

Mental Defectives

(See Table II, page 158.)

The total number of mental defectives in institutions in the United States on January 1, 1920, was 40,519. Of these, 34,836 were in state institutions, 2,732 in other public institutions and 2,951 in private institutions. Mental defectives were reported in state institutions in all states except Delaware, Georgia and New Mexico, although on January 1, 1920, there were 14 states that had no separate institutions caring for such patients. The mental defectives reported in state institutions in Alabama, Arizona, Arkansas, Florida, Louisiana, Mississippi, Nevada, South Carolina, Tennessee, Utah and West Virginia were cared for in hospitals for mental disease. Of the 34,836 mental defectives in state institutions, 28,833, or 82.8 per cent, were in state institutions especially established for their care.

Compared with the census of mental defectives of January 1, 1918, there has been an increase of 2,047 in state institutions, a decrease of 756 in other public institutions and a decrease of 153 in private institutions. The increase in total patients amounts to 1,138. As only a small portion of the total number of mental defectives is cared for in institutions the census throws no light on the prevalence of mental defect in the general population.

Sex of Mental Defectives in Institutions

Of the 40,519 mentally defective persons under treatment on January 1, 1920, 20,123 were males and 20,396 were females. In the several states there is considerable variation in the proportion of the two sexes found in institutions, but the differences in the various sections of the country in this respect are not nearly so great as are found in the figures relating to patients with mental disease.

Epileptics

(See Table III, page 159.)

Exclusive of the epileptics included among the patients with mental disease, there were on January 1, 1920, 14,937 epileptics under treatment in institutions of the United States. Of these, 13,223 were cared for in state institutions, 859 in other public institutions and 855 in private institutions. Compared with the census of January 1, 1918, there was an increase of 2,781 epileptics in state institutions, a decrease of 92 in other public institutions and an increase of 304 in private institutions. The total increase in all institutions was 2,993. The prevalence of epilepsy in the general population is not indicated by these figures as only a small proportion of the total number of epileptics is in institutions.

Colorado, Delaware, Georgia, Nebraska, New Mexico and Washington report no epileptics in state institutions other than those included among the patients with mental disease. In only 12 states are epileptics cared for in city or county institutions. Nearly one-half of the epileptics in private institutions are reported from Pennsylvania.

Sex of Epileptics in Institutions

Of the 14,937 epileptics in institutions on January 1, 1920, 7,939 were males and 6,998, females. In several states the two sexes are found in nearly equal numbers, but in Indiana, Kansas, Virginia, West Virginia and Wisconsin the male patients greatly exceed the female.

Alcoholics

(See Table IV, page 160.)

The alcoholics in institutions in the several states on January 1, 1920, other than those included among the patients with

mental disease, numbered 1,163. Of these, 587 were cared for in state institutions, 331 in other public institutions and 245 in private institutions.

In the census of 1918 the alcoholics and drug addicts were included in one group under the term "inebriates." In the present census the two classes were separated. In view of the oft-expressed opinion that the restrictions of the sale of alcoholic beverages would greatly increase the use of drugs, it is noteworthy that the total number of alcoholic and drug inebriates in institutions in the United States decreased from 3,565 on January 1, 1918, to 1,971 on January 1, 1920. On January 1, 1917, the total inebriates in institutions in this country numbered 4,891, or two and one-half times the number shown by the 1920 census.

While there are many alcoholics and drug addicts outside of institutions, the marked reduction of the number in institutions indicates that the number outside is also decreasing. This conclusion is further supported by the fact that the number of alcoholic and drug cases among first admissions to the New York State hospitals for mental diseases has markedly declined in recent years.

Of the 1,163 alcoholics in institutions on January 1, 1920, 217, or 18.7 per cent, were in Illinois; 137, or 11.8 per cent, in Iowa; 127, or 10.9 per cent, in Pennsylvania; 80, or 6.9 per cent, in Wisconsin; and 71, or 6.1 per cent, in New Jersey. The remaining 531, or 45.7 per cent, were scattered through 33 states. No alcoholics were reported from 10 states.

Nine hundred ninety-four of the alcoholics in institutions were males and 169 females, or 6 males to each female.

Drug Addicts

(See Table V, page 161.)

The drug addicts in institutions in the United States on January 1, 1920, numbered 808. Of these, 314 were in state institutions, 78 in other public institutions and 416 in private institutions. These figures throw little light on the prevalence of drug addiction as most drug addicts are not receiving institutional care. As no other separate census of drug addicts in

institutions has been taken in recent years no basis of comparison is available.

Of the 808 drug addicts in institutions 544 were males and 264 females, or 2 males to each female. New York is the only state in which the number of drug addicts reported reached 100.

Increase of Patients with Mental Disease in Institutions Compared with Increase of the General Population

(See Tables VI, VII and VIII, pages 162-66.)

The institutional care of the insane has increased enormously since 1880, when the first separate federal census of the insane in institutions was taken. The absolute numbers of patients under treatment as well as the rates of patients to population have increased at each succeeding census.

Patients with Mental Disease in Institutions, 1880–1920

Year	Number	Per 100,000 of general population
1880	40,942	81.6
1890	74,028	118.2
1904	150,151	183.6
1910	187,791	204.2
1918	223,957*	217.5
1920	232,680*	220.1

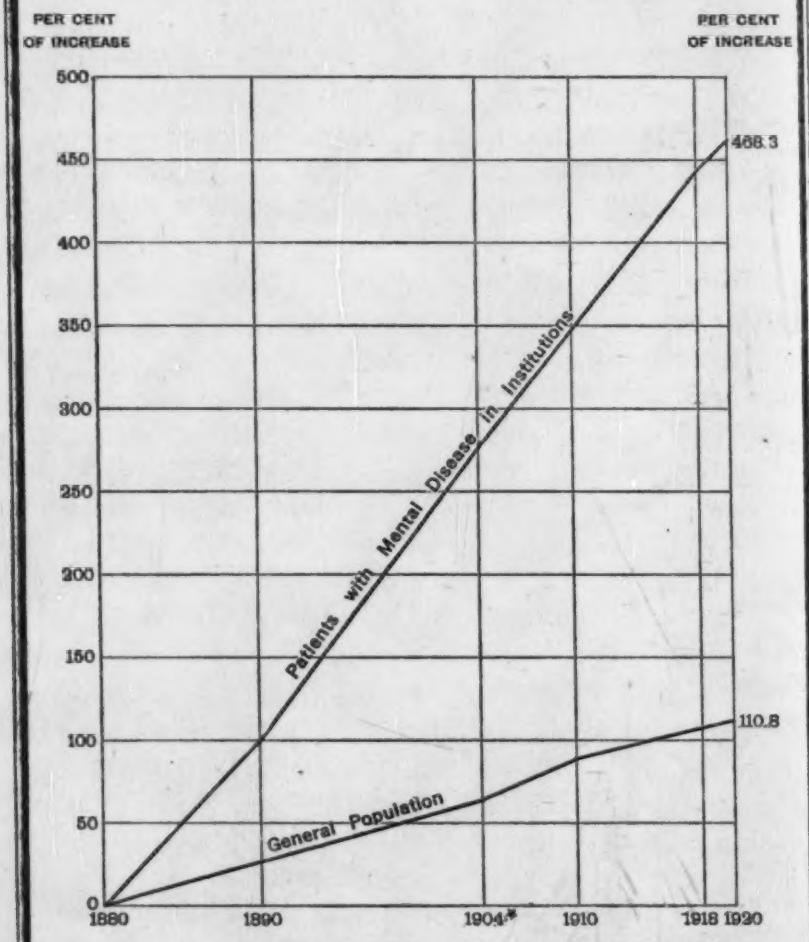
* Excluding paroles.

These figures indicate that a constantly increasing proportion of the insane is being cared for in institutions. That the rate of incidence of mental disease based on the general population has increased much less rapidly than that of institutional care is shown by the record of first admissions to the New York State hospitals during the past decade.*

Table VI shows the increase by sexes in the number of patients with mental disease in institutions in the several states from January 1, 1910, to January 1, 1920. The percentages of increase for the whole country were: males 22.6, females 25.3, total 23.9. The general population during the same period increased 14.9 per cent.

* *Thirty-first Annual Report of the State Hospital Commission.* Albany: New York State Hospital Commission, 1920. p. 275.

INCREASE OF PATIENTS WITH MENTAL DISEASE IN INSTITUTIONS COMPARED WITH INCREASE OF GENERAL POPULATION OF THE UNITED STATES, 1880-1920



*No special census of patients was taken in 1900

States with High Rates of Increase of Mental Patients under Treatment Compared with Increase of Population

State	Per cent of increase, 1910-1920	
	Patients	General population
California	53.1	44.1
Colorado	40.1	17.6
Florida	44.4	28.7
Idaho	40.5	32.6
Montana	58.1	46.0
New Mexico	62.6	10.1
North Dakota	97.9	11.9
Oklahoma	79.3	22.4
Oregon	55.7	16.4
Utah	56.1	20.4
Washington	72.3	18.8

In Vermont there was an increase of 10.6 per cent in mental patients and a decrease of 1.0 per cent in general population.

States with Low Rates of Increase of Mental Patients under Treatment Compared with Increase of Population

State	Per cent of increase, 1910-1920	
	Patients	General population
Alabama	9.8	9.8
Connecticut	22.6	23.9
Delaware	11.3	10.2
Illinois	15.9	15.0
Iowa	10.9	8.1
Kansas	4.9	4.6
Louisiana	8.9	8.6
Michigan	15.4	30.5
New Jersey	22.4	24.4
Ohio	15.3	20.8
West Virginia	5.0	19.9

The only states in which there was a decrease both in mental patients in institutions and in general population were Mississippi and Nevada.

The most remarkable result shown by the table is the disparity in the percentage increase in the number of patients of

the two sexes in certain states. Some of the most striking differences in percentages of increase are:

State	Percentage increase of patients, 1910-1920	
	Males	Females
Arizona	26.4	86.1
California	41.5	71.9
Colorado	34.8	47.3
Idaho	36.3	48.5
Kansas	0.3	11.2
Maine	18.5	46.2
Maryland	17.6	28.9
Missouri	7.3	18.4
Montana	38.0	122.3
Oklahoma	64.1	100.9
Oregon	48.6	71.9
South Carolina	29.5	17.3
South Dakota	29.3	48.9
Texas	29.2	46.9
Utah	70.2	42.1
Vermont	4.5	17.5
Washington	59.8	97.1
Wyoming	60.0	40.4

The causes of these remarkable inequalities in the increase of patients in the two sexes are not known. In Massachusetts, New York and Ohio the differences in the percentages of increase of patients in the two sexes are comparatively slight.

Table VII gives a comparison of the number and rate per 100,000 of patients with mental disease in the United States by divisions and states in 1910 and 1920. The rate of mental patients per 100,000 of general population increased from 204.2 in 1910 to 220.2 in 1920. The rates in the several divisions are shown in the following table:

Rates of Patients with Mental Disease in Institutions in the Several Divisions of the United States, 1910–1920

Division	Rank	Number per 100,000	
		1910	1920
New England	1	298.8	328.1
Middle Atlantic	2	271.2	292.3

Division	Rank	Number per 100,000 1910	1920
East North Central	4	226.0	225.1
West North Central	5	194.9	215.1
South Atlantic	6	163.6	171.0
East South Central	8	116.0	121.5
West South Central	9	95.8	111.1
Mountain	7	135.7	154.5
Pacific	3	243.4	288.2

The only division in which a decrease in the number of patients per 100,000 of population is shown is the East North Central. The decrease in this division may be accounted for by the rapid increase in population of Ohio and Michigan. The workers who have migrated to these states in the past three years are for the most part young and virile and have not resided there long enough to affect the population of the institutions. With the development of institutions for the insane in the Southern and Western states the rates of patients under treatment in the several divisions will become more nearly equal. A tendency to equalization is noticeable in the figures of 1910 and 1920. The accompanying chart gives a comparison of the rates of patients under treatment in the several states. New York heads the list with Massachusetts a close second.

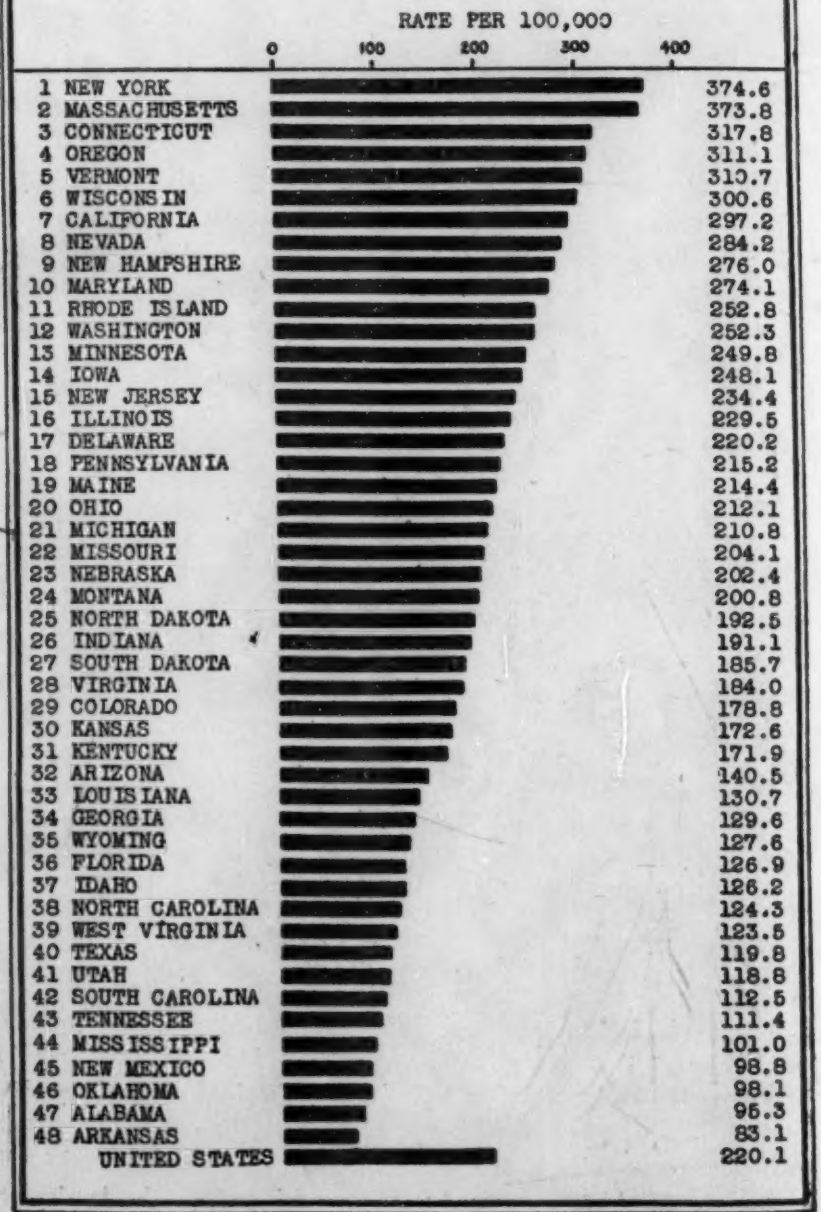
Table VIII gives a general view of the increase of patients with mental disease in institutions in the several states since 1890. It is noteworthy that the total number of patients has more than doubled during these three decades, while in several of the newer states the number of patients now cared for is more than five times the number cared for in 1890.

Patients Absent from Institutions but Still on Books

(See Table IX, page 167.)

The term "absent from institution, but still on books" includes patients on parole and escape or otherwise temporarily away from the institution. Owing to the lack of uniformity in the parole laws of the several states, the relation of the patients on parole to the institution is not the same in all cases. In Michigan, patients are considered on the books of the hospital for one year from the time of their discharge,

PATIENTS WITH MENTAL DISEASE IN INSTITUTIONS IN THE UNITED STATES, WITH RATES PER 100,000 OF GENERAL POPULATION, JANUARY 1, 1920



while in most states patients are temporarily released on parole pending their final discharge from the books of the institution. The period of parole varies from 30 days to 2 years, the most usual period being 6 months. In some states only private patients are paroled. Some states have a well organized system of after-care and supervision under the direction of social workers while other states exercise no supervision over patients on parole. The total number of patients reported as absent from state hospitals, but still on books on January 1, 1920, was 18,268, an increase of 2,405 since January 1, 1918. Owing to the different conditions under which patients are paroled, a comparison of the numbers and percentages on parole in the different states has little significance.

Increase of Mental Defectives in Institutions, 1910–1920

(See Table X, page 168.)

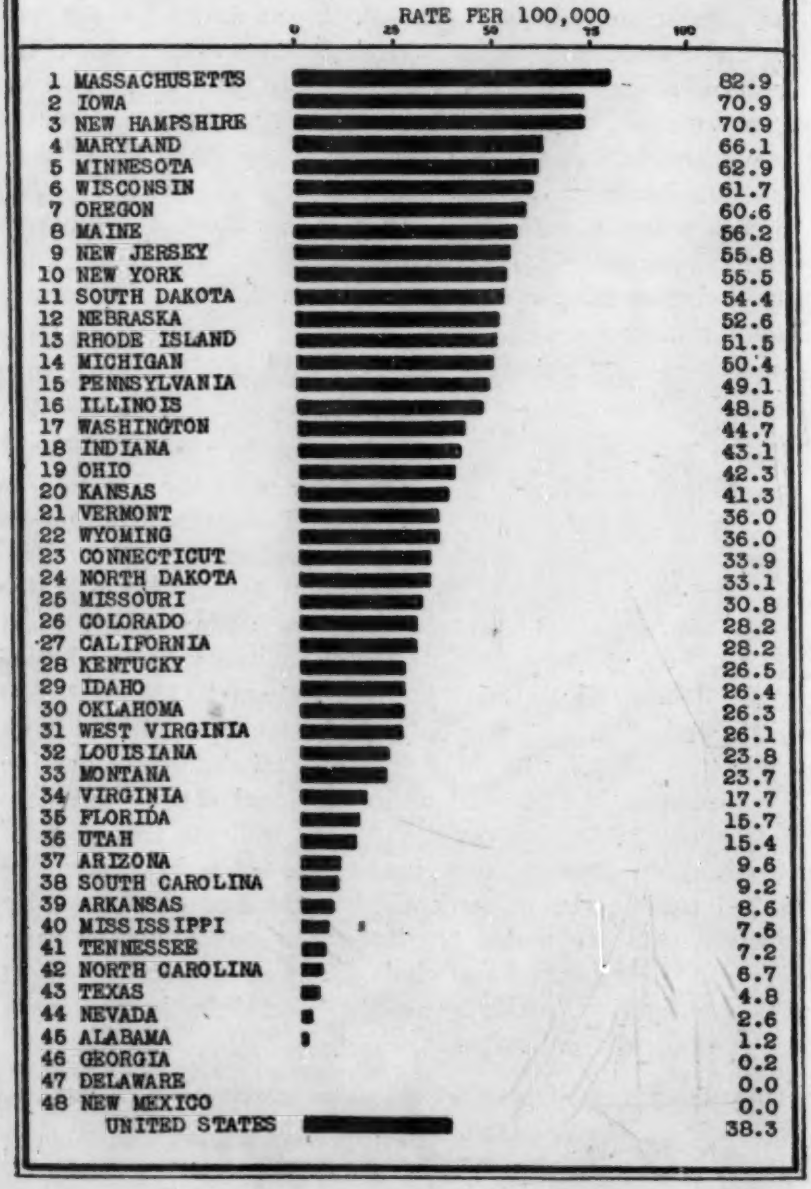
Table X shows the rapid development in the institutional care of mental defectives in many states of the Union. In 1910, when the federal census of mental defectives in institutions was taken, 17 of the 48 states reported no mental defectives in institutions. On January 1, 1920, all of the states except two reported mental defectives under institutional care. During the 10 years covered by the table the number of mentally defective patients increased from 20,731 to 40,519 and the rate of patients per 100,000 of general population from 22.5 to 38.3. While the number of mental defectives outside of institutions, but in need of institutional care is not definitely known, intensive county surveys indicate that present provision for them is very inadequate even in states like Massachusetts and New York where present rates of mentally defective patients under treatment are much higher than those for the country as a whole. The accompanying chart gives a comparison of the rates of mental defectives in institutions of the several states.

Patients in United States Public Health Service Hospitals, January 1, 1920

(See Table XI, page 169.)

At the time this census was taken, the United States Public Health Service had established or developed from existing

MENTAL DEFECTIVES IN INSTITUTIONS IN THE UNITED STATES, WITH RATES PER 100,000 OF GENERAL POPULATION, JANUARY 1, 1920



Marine Hospitals 43 hospitals in which ex-service men and women who were beneficiaries of the Bureau of War Risk Insurance were cared for. At the present time there are 54 such hospitals. Mental and nervous cases are admitted to nearly all these hospitals in emergencies and for temporary care, but an effort has been made to provide continued care only in special neuropsychiatric hospitals. In some of the larger general Public Health Service hospitals there are psychiatric wards. The special neuropsychiatric hospitals now receiving patients with psychoses are Public Health Service Hospital No. 44, at West Roxbury, Massachusetts; Public Health Service Hospital No. 49, at Philadelphia; and Public Health Service Hospital No. 57, at Knoxville, Iowa. Public Health Service Hospital No. 37, at Waukesha, Wisconsin, and Public Health Service Hospital No. 42, at Perryville, Maryland, are for psychoneuroses, and Public Health Service Hospital No. 34, at East Norfolk, Massachusetts, is for the treatment of epilepsy. As the legal residence of many of the patients in these institutions is in states other than those in which they are cared for, no attempt has been made to distribute these patients by states in the foregoing tables. The total patients in these institutions belonging to the several classes enumerated have been included in the tables for the country as a whole. As many soldiers and sailors with mental disease are being cared for in state and private institutions, the numbers given in Table XI give no indication of the extent to which former members of the army and navy are now being cared for in institutions.

New Institutions

The most noteworthy feature in the extension of institutional care since the publication of the 1918 census is the establishment of new state institutions for mental defectives, particularly in the South. Such institutions were authorized in 1918 by the legislatures in Louisiana and South Carolina; in 1919, in Alabama, Florida, Georgia, and Tennessee; and in 1920, in Mississippi. Of these institutions the ones in Mississippi and South Carolina have recently been opened, and it is expected that those in Florida and Georgia will be ready to receive mental defectives in the near future. A second insti-

tution for mental defectives in both Indiana and Ohio was authorized in 1919. The one in Indiana—The Farm Colony for the Feebleminded, located at Butlerville—is not yet ready to receive commitments, but is at present caring for a few male patients received by transfer from the Indiana School for Feebleminded Youth.

The Pacific Colony, California's second institution for mental defectives, authorized in 1917, will probably be opened in January, 1921. The first patients to be received will be 40 boys of the high-grade moron type who will assist in the development of the colony site. The Delaware state institution for mental defectives, which was authorized in 1917, is expected to open soon. The Idaho State Sanitarium, established by the 1913 legislature for the care of both mental defectives and epileptics, was opened in 1918. The 1919 legislature of Illinois changed the status of the Dixon State Colony, which was created by the legislature of 1913 and opened in 1918 as a separate institution for epileptics, so that this institution now receives both mental defectives and epileptics. The Southern Wisconsin Home for Feebleminded and Epileptics received its first patients on February 14, 1919. The Pennsylvania Village at Laurelton, authorized in 1913 as an institution for feebleminded women, received its first charges on January 2, 1920. Massachusetts' third institution for mental defectives, which was authorized by the 1915 legislature and located at Belchertown, is not yet completed, but was opened in 1919 to receive a few male patients. This institution is under the supervision of the Wrentham State School during construction.

A state psychopathic hospital was authorized in 1919 in Iowa to be located at the State University. The 1919 legislature of Colorado also enacted a law to establish a state psychopathic hospital, but without any appropriation for its construction or maintenance. The matter of appropriation was referred to the voters of Colorado at the 1920 election and the sum of $350,000 was thus authorized for this hospital. By an act of the 1920 legislature of Massachusetts, the Psychopathic Department of the Boston State Hospital was changed to a separate state hospital, to be known as The Boston Psychopathic Hospital.

Two state hospitals for mental diseases have been opened since 1918—The Western State Hospital for Insane, at Torrance, Pennsylvania, which was established by the 1915 legislature of that state, and the East Texas Hospital for the Insane, at Rusk, a hospital for colored patients, authorized in 1917.

The Marion Branch of the National Home for Disabled Volunteer Soldiers has recently been converted into the Marion National Sanatorium for the treatment of mental disorders.

A significant change in institutions is the discontinuance of hospitals for inebriates. In 1917, the Willmar State Asylum, Minnesota, opened in 1912 as a state hospital for inebriates, became a hospital for mental diseases. The Connecticut State Hospital for Inebriates, a department of the Norwich State Hospital, is now used as an integral part of the hospital and is receiving patients with mental diseases. Although this institution has not been closed by official action, it has ceased to function as a hospital for inebriates since February 1, 1920. The State Hospital for Inebriates, at Knoxville, Iowa, was officially closed, December 1, 1919. It is now United States Public Health Service Hospital No. 57, for the treatment of mental defectives. The Norfolk State Hospital, which was opened in 1914 to care for inebriates, is now United States Public Health Service Hospital No. 34, for the treatment of epilepsy. With the discontinuance of these four hospitals, there are at the present time no state hospitals for inebriates. The New York City Industrial Colony discontinued receiving inebriates in October, 1918, and was closed in December of that year.

Table I—Patients with mental disease in institutions in the several states of the Union, January 1, 1920*

STATE	TOTAL			PUBLIC									PRIVATE		
				STATE INSTITUTIONS			COUNTY OR CITY INSTITUTIONS			INSTITUTIONS FOR TEMPORARY CARE					
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
United States	121,031	111,649	232,680	105,134	94,975	200,109	10,855	10,729	21,584	561	481	1,040	3,773	5,465	9,238
Alabama	1,066	1,172	2,238	1,065	1,171	2,236	.....	.....	.....	.....	.....	.....	1	1	2
Arizona	335	134	469	335	134	469	.....	.....	.....	.....	.....	.....	.....	.....	.....
Arkansas	737	719	1,456	737	719	1,456	.....	.....	.....	.....	.....	.....	.....	.....	.....
California	5,823	4,361	10,184	5,688	4,240	9,928	.....	.....	.....	52	14	66	83	107	190
Colorado	926	754	1,680	872	702	1,574	.....	.....	.....	8	3	11	46	49	95
Connecticut	2,134	2,253	4,387	1,965	1,946	3,911	.....	.....	.....	.....	.....	.....	169	307	476
Delaware	256	235	491	256	235	491	.....	.....	.....	.....	.....	.....	.....	.....	.....
District of Columbia	2,494	848	3,342	2,436	845	3,281	.....	.....	.....	58	3	61	.....	.....	.....
Florida	638	588	1,226	638	588	1,226	.....	.....	.....	.....	.....	.....	.....	.....	.....
Georgia	1,831	1,923	3,754	1,806	1,881	3,687	.....	.....	.....	.....	.....	.....	25	42	67
Idaho	349	196	545	349	196	545	.....	.....	.....	.....	.....	.....	.....	.....	.....
Illinois	7,794	7,090	14,884	7,675	6,910	14,585	.....	.....	.....	47	40	87	72	140	212
Indiana	2,866	2,733	5,599	2,747	2,630	5,377	110	100	210	.....	.....	.....	9	3	12
Iowa	3,219	2,745	5,964	2,421	1,878	4,299	623	588	1,211	.....	.....	.....	175	279	454
Kansas	1,699	1,355	3,054	1,679	1,331	3,010	.....	.....	.....	.....	.....	.....	20	24	44
Kentucky	2,249	1,905	4,154	2,230	1,887	4,117	.....	.....	.....	.....	.....	.....	19	18	37
Louisiana	1,131	1,220	2,351	1,035	1,051	2,086	.....	.....	.....	39	36	75	57	133	190
Maine	821	826	1,647	813	812	1,625	.....	.....	.....	.....	.....	.....	8	14	22
Maryland	1,845	2,128	3,973	1,326	1,328	2,654	.....	.....	.....	117	145	262	402	655	1,057
Massachusetts	6,993	7,406	14,399	6,840	7,122	13,962	.....	.....	.....	41	42	83	112	242	354
Michigan	4,129	3,604	7,733	3,599	2,875	6,474	350	429	779	21	36	57	159	264	423
Minnesota	3,396	2,568	5,964	3,367	2,531	5,898	.....	.....	.....	.....	.....	.....	29	37	66
Mississippi	801	1,008	1,809	801	1,008	1,809	.....	.....	.....	.....	.....	.....	.....	.....	.....

Missouri	3,468	3,478	6,946	2,339	2,020	4,359	873	1,065	1,938	....	....	.....	256	393	649
Montana	733	369	1,102	733	369	1,102	.....	.....	.....	....	....	.....	.....	.....	.....
Nebraska	1,478	1,146	2,624	1,446	1,110	2,556	.....	.....	.....	....	....	.....	32	36	68
Nevada	159	61	220	159	61	220	.....	.....	.....	....	....	.....	.....	.....	.....
New Hampshire	605	618	1,223	605	618	1,223	.....	.....	.....	....	....	.....	.....	.....	.....
New Jersey	3,507	3,891	7,398	2,151	2,110	4,261	1,312	1,729	3,041	16	10	26	28	42	70
New Mexico	206	150	356	206	150	356	.....	.....	.....	....	....	.....	.....	.....	.....
New York	18,480	20,423	38,903	18,004	19,493	37,497	.....	.....	.....	84	89	173	392	841	1,233
North Carolina	1,343	1,837	3,180	1,320	1,795	3,115	.....	.....	.....	....	....	.....	23	42	65
North Dakota	801	442	1,243	801	442	1,243	.....	.....	.....	....	....	.....	.....	.....	.....
Ohio	6,483	5,734	12,217	6,370	5,568	11,938	.....	.....	.....	23	14	37	90	152	242
Oklahoma	1,068	922	1,990	1,004	840	1,844	.....	.....	.....	....	....	.....	64	82	146
Oregon	1,617	820	2,437	1,422	783	2,205	.....	.....	.....	....	....	.....	195	37	232
Pennsylvania	9,924	8,840	18,764	5,100	4,148	9,248	3,960	3,700	7,660	54	48	102	810	944	1,754
Rhode Island	794	734	1,528	729	670	1,399	.....	.....	.....	....	....	.....	65	64	129
South Carolina	917	977	1,894	915	965	1,880	.....	.....	.....	....	....	.....	2	12	14
South Dakota	692	490	1,182	692	490	1,182	.....	.....	.....	....	....	.....	.....	.....	.....
Tennessee	1,197	1,408	2,605	967	1,136	2,103	211	244	455	....	....	.....	19	28	47
Texas	2,697	2,889	5,586	2,619	2,789	5,408	.....	.....	.....	....	....	.....	78	100	178
Utah	291	243	534	291	243	534	.....	.....	.....	....	....	.....	.....	.....	.....
Vermont	552	543	1,095	338	354	692	.....	.....	.....	....	....	.....	214	189	403
Virginia	2,133	2,117	4,250	2,125	2,102	4,227	.....	.....	.....	....	....	.....	8	15	23
Washington	2,118	1,305	3,423	2,113	1,295	3,408	.....	.....	.....	....	....	.....	5	10	15
West Virginia	977	831	1,808	977	831	1,808	.....	.....	.....	....	....	.....	.....	.....	.....
Wisconsin	4,382	3,530	7,912	860	493	1,353	3,416	2,874	6,290	....	....	.....	106	163	269
Wyoming	168	80	248	168	80	248	.....	.....	.....	....	....	.....	.....	.....	.....
U. S. Public Health Service hospitals	709	.....	709	.....	.....	.....	.....	.....	.....	....	....	.....	.....	.....	.....

*Patients absent from institution but still on books are not included.

Table II—Mental defectives in institutions in the several states of the Union, January 1, 1920

STATE	TOTAL			PUBLIC						PRIVATE		
				STATE INSTITUTIONS			OTHER INSTITUTIONS					
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
United States	20,123	20,396	40,519	17,060	17,776	34,836	1,453	1,279	2,732	1,610	1,341	2,951
Alabama	11	18	29	11	18	29						
Arizona	18	14	32	18	14	32						
Arkansas	75	75	150	75	75	150						
California	474	491	965	463	471	934				11	20	31
Colorado	163	102	265	148	94	242				15	8	23
Connecticut	247	221	468	237	212	449				10	9	19
Delaware												
Dist. of Columbia	5	1	6				5	1	6			
Florida	79	73	152	79	73	152						
Georgia	6		6							6		6
Idaho	63	51	114	63	51	114						
Illinois	1,677	1,470	3,147	1,640	1,427	3,067				37	43	80
Indiana	582	682	1,264	561	668	1,229	21	14	35			
Iowa	860	844	1,704	710	705	1,415	124	105	229	26	34	60
Kansas	359	372	731	358	372	730				1		1
Kentucky	337	304	641	280	276	556				57	28	85
Louisiana	234	194	428	225	141	366	2	3	5	7	50	57
Maine	229	203	432	229	203	432						
Maryland	463	495	958	443	460	903	18	9	27	2	26	28
Massachusetts	1,678	1,514	3,192	1,627	1,459	3,086				51	55	106
Michigan	990	859	1,849	933	816	1,749	5	3	8	52	40	92
Minnesota	764	738	1,502	744	719	1,463				20	19	39
Mississippi	79	57	136	79	57	136						
Missouri	525	522	1,047	371	352	723	109	102	211	45	68	113
Montana	86	44	130	86	44	130						
Nebraska	359	323	682	359	320	679					3	3
Nevada	2		2	2		2						
New Hampshire	150	164	314	150	164	314						
New Jersey	709	1,053	1,762	183	779	962	118	102	220	408	172	580
New Mexico												
New York	2,660	3,102	5,762	1,786	2,279	4,065	699	647	1,346	175	176	351
North Carolina	74	97	171	74	96	170					1	1
North Dakota	118	96	214	118	96	214						
Ohio	1,211	1,224	2,435	1,206	1,222	2,428	1	1	2	4	1	5
Oklahoma	297	237	534	296	236	532				1	1	2
Oregon	216	259	475	209	256	465				7	3	10
Pennsylvania	2,147	2,134	4,281	1,531	1,627	3,158	178	129	307	438	378	816
Rhode Island	148	163	311	148	163	311						
South Carolina	85	70	155	85	70	155						
South Dakota	194	152	346	194	152	346						
Tennessee	83	86	169	32	26	58	39	50	89	12	10	22
Texas	70	154	224	48	140	188				22	14	36
Utah	29	40	69	29	40	69						
Vermont	44	83	127	31	73	104				13	10	23
Virginia	144	264	408	102	216	318				42	48	90
Washington	331	275	606	330	275	605				1		1
West Virginia	197	185	382	197	185	382						
Wisconsin	760	864	1,624	527	627	1,154	86	113	199	147	124	271
Wyoming	43	27	70	43	27	70						
U.S. Public Health Service hospitals	48		48				48		48			

Table III—Epileptics in institutions in the several states of the Union, January 1, 1920

STATE	TOTAL			PUBLIC						PRIVATE		
				STATE INSTITUTIONS			OTHER INSTITUTIONS					
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
United States	7,939	6,998	14,937	7,040	6,183	13,223	500	359	859	399	456	855
Alabama	3	6	9	3	6	9	....	....	....	....	....	....
Arizona	12	....	12	12	....	12	....	....	....	....	....	....
Arkansas	100	100	200	100	100	200	....	....	....	....	....	....
California	247	200	447	234	194	428	10	....	10	3	6	9
Colorado	5	....	5	....	....	....	....	....	....	5	....	5
Connecticut	55	61	116	48	52	100	....	....	....	7	9	16
Delaware	....	....	....	....	....	....	....	....	....	....	....	....
Dist. of Columbia	3	....	3	....	....	....	3	....	3	....	....	....
Florida	63	57	120	63	57	120	....	....	....	....	....	....
Georgia	1	4	5	....	....	....	....	....	....	1	4	5
Idaho	15	18	33	15	18	33	....	....	....	....	....	....
Illinois	382	405	787	375	395	770	1	....	1	6	10	16
Indiana	442	155	597	442	146	588	....	9	9	....	....	....
Iowa	266	237	503	242	214	456	24	23	47	....	....	....
Kansas	306	235	541	306	235	541	....	....	....	....	....	....
Kentucky	87	77	164	80	72	152	....	....	....	7	5	12
Louisiana	69	54	123	63	42	105	1	2	3	5	10	15
Maine	34	24	58	34	24	58	....	....	....	....	....	....
Maryland	75	74	149	70	48	118	....	....	....	5	26	31
Massachusetts	615	612	1,227	566	580	1,146	....	....	....	49	32	81
Michigan	426	416	842	423	416	839	....	....	....	3	....	3
Minnesota	149	160	309	147	159	306	....	....	....	2	1	3
Mississippi	90	88	178	90	88	178	....	....	....	....	....	....
Missouri	356	388	744	243	248	491	86	86	172	27	54	81
Montana	50	18	68	50	18	68	....	....	....	....	....	....
Nebraska	1	....	1	....	....	....	....	....	....	1	....	1
Nevada	1	2	3	1	2	3	....	....	....	....	....	....
New Hampshire	27	43	70	27	43	70	....	....	....	....	....	....
New Jersey	404	413	817	373	393	766	17	13	30	14	7	21
New Mexico	....	....	....	....	....	....	....	....	....	....	....	....
New York	842	841	1,683	712	703	1,415	102	118	220	28	20	48
North Carolina	96	86	182	93	83	176	....	....	....	3	3	6
North Dakota	35	34	69	35	34	69	....	....	....	....	....	....
Ohio	866	814	1,680	863	813	1,676	3	1	4	....	....	....
Oklahoma	193	172	365	188	171	359	....	....	....	5	1	6
Oregon	14	4	18	12	4	16	....	....	....	2	....	2
Pennsylvania	461	420	881	233	166	399	54	35	89	174	219	393
Rhode Island	19	17	36	18	17	35	....	....	....	1	....	1
South Carolina	80	65	145	80	65	145	....	....	....	....	....	....
South Dakota	2	3	5	2	3	5	....	....	....	....	....	....
Tennessee	66	39	105	43	23	66	23	16	39	....	....	....
Texas	294	259	553	292	257	549	....	....	....	2	2	4
Utah	12	16	28	12	16	28	....	....	....	....	....	....
Vermont	10	14	24	4	11	15	....	....	....	6	3	9
Virginia	266	168	434	260	157	417	....	....	....	6	11	17
Washington	....	....	....	....	....	....	....	....	....	....	....	....
West Virginia	165	94	259	165	94	259	....	....	....	....	....	....
Wisconsin	125	97	222	13	8	21	75	56	131	37	33	70
Wyoming	8	8	16	8	8	16	....	....	....	....	....	....
U. S. Public Health Service hospitals	101	....	101	....	....	....	101	....	101	....	....	....

Table IV—Alcoholics in institutions in the several states of the Union, January 1, 1920

(States reporting no alcoholics are omitted)

STATE	TOTAL			PUBLIC						PRIVATE		
				STATE INSTITUTIONS			OTHER INSTITUTIONS					
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
United States	994	169	1,163	507	80	587	284	47	331	203	42	245
Alabama	1	.....	1	1	.....	1	.....	.....	.....	.....	.....	.....
Arizona	3	.....	3	3	.....	3	.....	.....	.....	.....	.....	.....
Arkansas	3	.....	3	3	.....	3	.....	.....	.....	.....	.....	.....
California	30	11	41	27	10	37	.....	1	1	3	....	3
Colorado	11	.....	11	11	.....	11	.....	.....	.....	.....	.....	.....
Connecticut	8	1	9	.....	.....	.....	.....	.....	.....	8	1	9
Dist. of Columbia	2	.....	2	.....	.....	.....	2	.....	2	.....	.....	.....
Georgia	4	.....	4	.....	.....	.....	.....	.....	.....	4	.....	4
Idaho	9	.....	9	9	.....	9	.....	.....	.....	.....	.....	.....
Illinois	194	23	217	190	21	211	.....	.....	.....	4	2	6
Indiana	1	.....	1	1	.....	1	.....	.....	.....	.....	.....	.....
Iowa	113	24	137	30	3	33	80	21	101	3	.....	3
Kansas	1	.....	1	.....	.....	.....	.....	.....	.....	1	.....	1
Kentucky	1	.....	1	.....	.....	.....	.....	.....	.....	1	.....	1
Louisiana	26	6	32	11	5	16	2	.....	2	13	1	14
Maine	12	1	13	12	1	13	.....	.....	.....	.....	.....	.....
Maryland	53	8	61	44	8	52	2	.....	2	7	.....	7
Massachusetts	4	12	16	.....	.....	.....	.....	.....	.....	4	12	16
Michigan	13	2	15	7	2	9	.....	.....	.....	6	.....	6
Minnesota	42	.....	42	40	.....	40	.....	.....	.....	2	.....	2
Mississippi	7	.....	7	7	.....	7	.....	.....	.....	.....	.....	.....
Missouri	23	10	33	3	2	5	3	8	11	17	.....	17
Montana	22	9	31	22	9	31	.....	.....	.....	.....	.....	.....
Nebraska	1	.....	1	1	.....	1	.....	.....	.....	.....	.....	.....
Nevada	18	9	27	18	9	27	.....	.....	.....	.....	.....	.....
New Hampshire	1	.....	1	1	.....	1	.....	.....	.....	.....	.....	.....
New Jersey	61	10	71	36	8	44	25	2	27	.....	.....	.....
New York	48	9	57	.....	.....	.....	40	7	47	8	2	10
Ohio	9	1	10	.....	.....	.....	6	1	7	3	.....	3
Oklahoma	17	.....	17	13	.....	13	.....	.....	.....	4	.....	4
Pennsylvania	103	24	127	.....	.....	.....	40	3	43	63	21	84
South Carolina	1	.....	1	.....	.....	.....	.....	.....	.....	1	.....	1
South Dakota	1	.....	1	1	.....	1	.....	.....	.....	.....	.....	.....
Tennessee	18	.....	18	3	.....	3	10	.....	10	5	.....	5
Texas	8	2	10	.....	.....	.....	.....	.....	.....	8	2	10
Vermont	29	1	30	1	.....	1	.....	.....	.....	28	1	29
Virginia	11	1	12	3	1	4	.....	.....	.....	8	.....	8
West Virginia	3	1	4	3	1	4	.....	.....	.....	.....	.....	.....
Wisconsin	76	4	80	6	.....	6	68	4	72	2	.....	2
U. S. Public Health Service hospitals	6	.....	6	.....	.....	.....	6	.....	6	.....	.....	.....

Table V—Drug addicts in institutions in the several states of the Union, January 1, 1920

(States reporting no drug addicts are omitted)

STATE	TOTAL			PUBLIC						PRIVATE		
				STATE INSTITUTIONS			OTHER INSTITUTIONS					
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
United States	544	264	808	207	107	314	44	34	78	293	123	416
Alabama	5	1	6	3	1	4	.....	.....	.....	2	.....	2
Arizona	3	.....	3	3	.....	3	.....	.....	.....	.....	.....	.....
Arkansas	6	2	8	6	2	8	.....	.....	.....	.....	.....	.....
California	34	18	52	30	14	44	1	2	3	3	2	5
Colorado	.....	4	4	.....	3	3	.....	.....	.....	.....	1	1
Connecticut	4	.....	4	.....	.....	.....	.....	.....	.....	4	.....	4
Dist. of Columbia	3	.....	3	.....	.....	.....	3	.....	3	.....	.....	.....
Florida	4	3	7	4	3	7	.....	.....	.....	.....	.....	.....
Georgia	10	4	14	.....	.....	.....	.....	.....	.....	10	4	14
Illinois	60	28	88	56	22	78	.....	.....	.....	4	6	10
Indiana	2	.....	2	2	.....	2	.....	.....	.....	.....	.....	.....
Iowa	5	9	14	1	6	7	4	3	7	.....	.....	.....
Kansas	1	1	2	1	1	2	.....	.....	.....	.....	.....	.....
Kentucky	2	.....	2	.....	.....	.....	.....	.....	.....	2	.....	2
Louisiana	24	1	25	2	1	3	.....	.....	.....	22	.....	22
Maine	1	2	3	1	2	3	.....	.....	.....	.....	.....	.....
Maryland	4	9	13	.....	3	3	.....	1	1	4	5	9
Massachusetts	1	2	3	.....	.....	.....	.....	.....	.....	1	2	3
Michigan	12	13	25	11	9	20	.....	2	2	1	2	3
Minnesota	2	3	5	.....	.....	.....	.....	.....	.....	2	3	5
Mississippi	10	4	14	10	4	14	.....	.....	.....	.....	.....	.....
Missouri	23	10	33	9	6	15	.....	.....	.....	14	4	18
Montana	22	4	26	22	4	26	.....	.....	.....	.....	.....	.....
Nebraska	5	2	7	5	2	7	.....	.....	.....	.....	.....	.....
New Jersey	7	1	8	3	1	4	1	.....	1	3	.....	3
New York	107	49	156	.....	.....	.....	8	10	18	99	39	138
North Carolina	9	6	15	.....	.....	.....	.....	.....	.....	9	6	15
Ohio	13	9	22	8	6	14	4	2	6	1	1	2
Oklahoma	31	12	43	3	3	6	.....	.....	.....	28	9	37
Oregon	4	3	7	2	1	3	.....	.....	.....	2	2	4
Pennsylvania	22	15	37	.....	.....	.....	1	3	4	21	12	33
Tennessee	30	17	47	5	4	9	10	9	19	15	4	19
Texas	25	11	36	.....	.....	.....	.....	.....	.....	25	11	36
Utah	1	1	2	1	1	2	.....	.....	.....	.....	.....	.....
Vermont	22	12	34	9	3	12	.....	.....	.....	13	9	22
Virginia	10	3	13	3	2	5	.....	.....	.....	7	1	8
West Virginia	6	1	7	6	1	7	.....	.....	.....	.....	.....	.....
Wisconsin	2	4	6	1	2	3	.....	2	2	1	.....	1
U. S. Public Health Service hospitals	12	.....	12	.....	.....	.....	12	.....	12	.....	.....	.....

Table VI—Increase in number of patients with mental disease in institutions in the several states of the Union, from January 1, 1910, to January 1, 1920, compared with increase of general population

STATE	Patients with Mental Disease												Per cent increase of general population from 1910 to 1920
	January 1, 1910			January 1, 1920			Increase from 1910 to 1920						
							Number			Per cent			
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	
United States	98,695	89,096	187,791	121,031†	111,649	232,680†	22,336	22,553	44,889	22.6	25.3	23.9	14.9
Alabama	981	1,058	2,039	1,066	1,172	2,238	85	114	199	8.7	10.8	9.8	9.8
Arizona	265	72	337	335	134	469	70	62	132	26.4	86.1	39.2	63.4
Arkansas	529	563	1,092	737	719	1,456	208	156	364	39.3	27.7	33.3	11.3
California	4,115	2,537	6,652	5,823	4,361	10,184	1,708	1,824	3,532	41.5	71.9	53.1	44.1
Colorado	687	512	1,199	926	754	1,680	239	242	481	34.8	47.3	40.1	17.6
Connecticut	1,680	1,899	3,579	2,134	2,253	4,387	454	354	808	27.0	18.6	22.6	23.9
Delaware	237	204	441	256	235	491	19	31	50	8.0	15.2	11.3	10.2
Dist. of Columbia	2,170	720	2,890	2,494	848	3,342	324	128	452	14.9	17.8	15.6	32.2
Florida	446	403	849	638	588	1,226	192	185	377	43.0	45.9	44.4	28.7
Georgia	1,531	1,601	3,132	1,831	1,923	3,754	300	322	622	19.6	20.1	19.9	11.0
Idaho	256	132	388	349	196	545	93	64	157	36.3	48.5	40.5	32.6
Illinois	6,846	5,993	12,839	7,794	7,090	14,884	948	1,097	2,045	13.8	18.3	15.9	15.0
Indiana	2,235	2,292	4,527	2,866	2,733	5,599	631	441	1,072	28.2	19.2	23.7	8.5
Iowa	2,896	2,481	5,377	3,219	2,745	5,964	323	264	587	11.2	10.6	10.9	8.1
Kansas	1,694	1,218	2,912	1,699	1,355	3,054	5	137	142	0.3	11.2	4.9	4.6
Kentucky	1,968	1,570	3,538	2,249	1,905	4,154	281	335	616	14.3	21.3	17.4	5.5
Louisiana	1,070	1,088	2,158	1,131	1,220	2,351	61	132	193	5.7	12.1	8.9	8.6
Maine	693	565	1,258	821	826	1,647	128	261	389	18.5	46.2	30.9	3.5
Maryland	1,569	1,651	3,220	1,845	2,128	3,973	276	477	753	17.6	28.9	23.4	11.9

Massachusetts	5,633	5,968	11,601	6,993	7,406	14,399	1,360	1,438	2,798	24.1	24.1	24.1	14:4
Michigan	3,679	3,020	6,699	4,129	3,604	7,733	450	584	1,034	12.2	19.3	15.4	30.5
Minnesota	2,755	1,989	4,744	3,396	2,568	5,964	641	579	1,220	23.3	29.1	25.7	15.0
Mississippi	933	1,045	1,978	801	1,008	1,809	132*	37*	169*	14.1*	3.5*	8.5*	0.4*
Missouri	3,231	2,937	6,168	3,468	3,478	6,946	237	541	778	7.3	18.4	12.6	3.4
Montana	531	166	697	733	369	1,102	202	203	405	38.0	122.3	58.1	46.0
Nebraska	1,141	849	1,990	1,478	1,146	2,624	337	297	634	29.5	35.0	31.9	8.7
Nevada	165	65	230	159	61	220	6*	4*	10*	3.6*	6.2*	4.3*	5.5*
New Hampshire	463	446	909	605	618	1,223	142	172	314	30.7	38.6	34.5	2.9
New Jersey	2,913	3,129	6,042	3,507	3,891	7,398	594	762	1,356	20.4	24.4	22.4	24.4
New Mexico	128	91	219	206	150	356	78	59	137	60.9	64.8	62.6	10.1
New York	14,955	16,325	31,280	18,480	20,423	38,903	3,525	4,098	7,623	23.6	25.1	24.4	13.9
North Carolina	1,032	1,490	2,522	1,343	1,837	3,180	311	347	658	30.1	23.3	26.1	16.0
North Dakota	407	221	628	801	442	1,243	394	221	615	96.8	100.0	97.9	11.9
Ohio	5,615	4,979	10,594	6,483	5,734	12,217	868	755	1,623	15.5	15.2	15.3	20.8
Oklahoma	651	459	1,110	1,068	922	1,990	417	463	880	64.1	100.9	79.3	22.4
Oregon	1,088	477	1,565	1,617	820	2,437	529	343	872	48.6	71.9	55.7	16.4
Pennsylvania	7,919	7,139	15,058	9,924	8,840	18,764	2,005	1,701	3,706	25.3	23.8	24.6	13.8
Rhode Island	650	593	1,243	794	734	1,528	144	141	285	22.2	23.8	22.9	11.4
South Carolina	708	833	1,541	917	977	1,894	209	144	353	29.5	17.3	22.9	11.1
South Dakota	535	329	864	692	490	1,182	157	161	318	29.3	48.9	36.8	9.0
Tennessee	1,057	1,147	2,204	1,197	1,408	2,605	140	261	401	13.2	22.8	18.2	7.0
Texas	2,087	1,966	4,053	2,697	2,889	5,586	610	923	1,533	29.2	46.9	37.8	19.7
Utah	171	171	342	291	243	534	120	72	192	70.2	42.1	56.1	20.4
Vermont	528	462	990	552	543	1,095	24	81	105	4.5	17.5	10.6	1.0*
Virginia	1,779	1,856	3,635	2,133	2,117	4,250	354	261	615	19.9	14.1	16.9	12.0
Washington	1,325	662	1,987	2,118	1,305	3,423	793	643	1,436	59.8	97.1	72.3	18.8
West Virginia	900	822	1,722	977	831	1,808	77	9	86	8.6	1.1	5.0	19.9
Wisconsin	3,743	2,844	6,587	4,382	3,530	7,912	639	686	1,325	17.1	24.1	20.1	12.8
Wyoming	105	57	162	168	80	248	63	23	86	60.0	40.4	53.1	33.2

* Decrease.

† Includes 709 patients in United States Public Health Service hospitals.

Table VII—Patients with mental disease in institutions in the United States by divisions and states, with rates per 100,000 of general population, on January 1 of 1910 and 1920

STATE	NUMBER		RATE PER 100,000 OF GENERAL POPULATION	
	1910	1920*	1910	1920
United States	187,791	232,680	204.2	220.1
New England	19,580	24,279	298.8	328.1
Maine	1,258	1,647	169.5	214.4
New Hampshire	909	1,223	211.1	276.0
Vermont	990	1,095	278.1	310.7
Massachusetts	11,601	14,399	344.6	373.8
Rhode Island	1,243	1,528	229.1	252.8
Connecticut	3,579	4,387	321.1	317.8
Middle Atlantic	52,380	65,065	271.2	292.3
New York	31,280	38,903	343.2	374.6
New Jersey	6,042	7,398	238.1	234.4
Pennsylvania	15,058	18,764	196.4	215.2
East North Central	41,246	48,345	226.0	225.1
Ohio	10,594	12,217	222.2	212.1
Indiana	4,527	5,599	167.6	191.1
Illinois	12,839	14,884	227.7	229.5
Michigan	6,699	7,733	238.4	210.8
Wisconsin	6,587	7,912	282.2	300.6
West North Central	22,683	26,977	194.9	215.1
Minnesota	4,744	5,964	228.5	249.8
Iowa	5,377	5,964	241.7	248.1
Missouri	6,168	6,946	187.3	204.1
North Dakota	628	1,243	108.8	192.5
South Dakota	864	1,182	148.0	185.7
Nebraska	1,990	2,624	166.9	202.4
Kansas	2,912	3,054	172.2	172.6
South Atlantic	19,952	23,918	163.6	171.0
Delaware	441	491	218.0	220.2
Maryland	3,220	3,973	248.6	274.1
Dist. of Columbia	2,890	3,342	872.9	763.8
Virginia	3,635	4,250	176.3	184.0
West Virginia	1,722	1,808	141 0	123.5
North Carolina	2,522	3,180	114.3	124.3
South Carolina	1,541	1,894	101.7	112.5
Georgia	3,132	3,754	120.0	129.6
Florida	849	1,226	112.8	126.9
East South Central	9,759	10,806	116.0	121.5
Kentucky	3,538	4,154	154.5	171.9
Tennessee	2,204	2,605	100.9	111.4
Alabama	2,039	2,238	95.4	95.3
Mississippi	1,978	1,809	110.1	101.0

Table VII—Patients with mental disease in institutions in the United States by divisions and states, with rates per 100,000 of general population, on January 1 of 1910 and 1920—Concluded

STATE	NUMBER		RATE PER 100,000 OF GENERAL POPULATION	
	1910	1920*	1910	1920
West South Central	8,413	11,383	95.8	111.1
Arkansas	1,092	1,456	69.4	83.1
Louisiana	2,158	2,351	130.3	130.7
Oklahoma	1,110	1,990	67.0	98.1
Texas	4,053	5,586	104.0	119.8
Mountain	3,574	5,154	135.7	154.5
Montana	697	1,102	185.3	200.8
Idaho	388	545	119.2	126.2
Wyoming	162	248	111.0	127.6
Colorado	1,199	1,680	150.1	178.8
New Mexico	219	356	66.9	98.8
Arizona	337	469	164.9	140.5
Utah	342	534	91.6	118.8
Nevada	230	220	280.9	284.2
Pacific	10,204	16,044	243.4	288.2
Washington	1,987	3,423	174.0	252.3
Oregon	1,565	2,437	232.6	311.1
California	6,652	10,184	279.8	297.2

* Includes 709 patients in United States Public Health Service hospitals.

Table VIII—Patients with mental disease in institutions in the several states of the Union, with rates per 100,000 of general population, in 1890, 1904, 1910, and 1920

STATE	JUNE 1, 1890		JANUARY 1, 1904		JANUARY 1, 1910		JANUARY 1, 1920	
	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000
United States	106,485	170.0	150,151	183.6	187,791	204.2	232,680*	220.1
Alabama	1,469	97.1	1,603	82.6	2,039	95.4	2,238	95.3
Arizona	64	107.3	224	146.9	337	164.9	469	140.5
Arkansas	790	70.0	667	47.4	1,092	69.4	1,456	83.1
California	3,736	309.2	5,717	316.0	6,652	279.8	10,184	297.2
Colorado	326	79.1	754	119.0	1,199	150.1	1,680	178.8
Connecticut	2,056	275.5	2,831	287.9	3,579	321.1	4,387	317.8
Delaware	197	116.9	353	184.7	441	218.0	491	220.2
Dist. of Columbia	1,578	684.9	2,453	823.9	2,890	872.9	3,342	763.8
Florida	351	89.7	713	116.9	849	112.8	1,226	126.9
Georgia	1,815	98.8	2,839	120.4	3,132	120.0	3,754	129.6
Idaho	83	98.4	255	115.3	388	119.2	545	126.2
Illinois	6,641	173.6	9,607	187.7	12,839	227.7	14,884	229.5
Indiana	3,291	150.1	4,358	168.7	4,527	167.6	5,599	191.1
Iowa	3,197	167.2	4,385	196.7	5,377	241.7	5,964	248.1
Kansas	1,794	125.7	2,460	158.7	2,912	172.2	3,054	172.6
Kentucky	2,729	146.8	3,058	139.1	3,538	154.5	4,154	171.9
Louisiana	910	81.4	1,585	107.0	2,158	130.3	2,351	130.7
Maine	1,299	196.5	885	124.3	1,258	169.5	1,647	214.4
Maryland	1,646	157.9	2,505	204.2	3,220	248.6	3,973	274.1
Massachusetts	6,103	272.6	8,679	288.4	11,601	344.6	14,399	373.8
Michigan	3,725	177.9	5,430	211.9	6,699	238.4	7,733	210.8
Minnesota	2,205	169.4	4,070	217.8	4,744	228.5	5,964	249.8
Mississippi	1,104	85.6	1,493	91.0	1,978	110.1	1,809	101.0
Missouri	3,418	127.6	5,103	160.8	6,168	187.3	6,946	204.1
Montana	192	145.3	543	186.3	697	185.3	1,102	200.8
Nebraska	932	88.0	1,536	138.1	1,990	166.9	2,624	202.4
Nevada	183	399.9	200	352.8	230	280.9	220	284.2
New Hampshire	961	255.2	496	118.5	909	211.1	1,223	276.0
New Jersey	3,163	218.9	4,865	229.4	6,042	238.1	7,398	234.4
New Mexico	66	43.0	113	46.5	219	66.9	356	98.8
New York	17,846	297.5	26,176	329.7	31,280	343.2	38,903	374.6
North Carolina	1,725	106.6	1,883	93.8	2,522	114.3	3,180	124.3
North Dakota	221	121.0	446	108.1	628	108.8	1,243	192.5
Ohio	7,600	207.0	8,621	196.9	10,594	222.2	12,217	212.1
Oklahoma	7	11.3	413	37.4	1,110	67.0	1,990	98.1
Oregon	640	204.0	1,285	253.2	1,565	232.6	2,437	311.1
Pennsylvania	8,482	161.3	11,521	169.5	15,058	196.4	18,764	215.2
Rhode Island	795	230.1	1,077	229.2	1,243	229.1	1,528	252.8
South Carolina	912	79.2	1,156	82.3	1,541	101.7	1,894	112.5
South Dakota	310	94.3	595	127.2	864	148.0	1,182	185.7
Tennessee	1,845	104.4	1,713	82.3	2,204	100.9	2,605	111.4
Texas	1,670	74.7	3,345	99.7	4,053	104.0	5,586	119.8
Utah	166	79.8	344	110.3	342	91.6	534	118.8
Vermont	823	247.6	887	254.8	990	278.1	1,095	310.7
Virginia	2,407	145.4	3,137	162.6	3,635	176.3	4,250	184.0
Washington	380	108.8	1,178	158.2	1,987	174.0	3,423	252.3
West Virginia	1,079	141.5	1,475	139.9	1,722	141.0	1,808	123.5
Wisconsin	3,513	208.3	5,023	232.0	6,587	282.2	7,912	300.6
Wyoming	40	65.9	96	85.8	162	111.0	248	127.6

*Includes 709 patients in United States Public Health Service hospitals.

Table IX—Patients with mental disease in state institutions, and absent from institutions but still on books, in the several states of the Union, January 1, 1920

STATE	In State Institutions			Absent from Institutions but Still on Books			Per cent absent of total on books
	M.	F.	T.	M.	F.	T.	
United States	105,134	94,975	200,109	9,381	8,887	18,268	9.1
Alabama	1,065	1,171	2,236	156	147	303	11.9
Arizona	335	134	469	7	4	11	2.3
Arkansas	737	719	1,456	355	345	700	32.5
California	5,688	4,240	9,928	542	526	1,068	9.7
Colorado	872	702	1,574	108	79	187	10.6
Connecticut	1,965	1,946	3,911	92	110	202	4.9
Delaware	256	235	491	8	8	16	3.2
Dist. of Columbia	2,436	845	3,281	86	40	126	3.7
Florida	638	588	1,226	.....	.....	.....	.....
Georgia	1,806	1,881	3,687	102	92	194	5.0
Idaho	349	196	545	34	18	52	8.7
Illinois	7,675	6,910	14,585	416	330	746	4.9
Indiana	2,747	2,630	5,377	186	198	384	6.7
Iowa	2,421	1,878	4,299	469	453	922	17.7
Kansas	1,679	1,331	3,010	154	140	294	8.9
Kentucky	2,230	1,887	4,117	129	100	229	5.3
Louisiana	1,035	1,051	2,086	17	5	22	1.0
Maine	813	812	1,625	114	111	225	12.2
Maryland	1,326	1,328	2,654	.....	.....	.....	.....
Massachusetts	6,840	7,122	13,962	893	1,081	1,974	12.4
Michigan	3,599	2,875	6,474	*	*	*	*
Minnesota	3,367	2,531	5,898	450	391	841	12.5
Mississippi	801	1,008	1,809	28	40	68	3.6
Missouri	2,339	2,020	4,359	157	83	240	5.2
Montana	733	369	1,102	*	*	*	*
Nebraska	1,446	1,110	2,556	112	111	223	8.0
Nevada	159	61	220	6	7	13	5.6
New Hampshire	605	618	1,223	35	42	77	5.9
New Jersey	2,151	2,110	4,261	81	99	180	4.1
New Mexico	206	150	356	48	21	69	16.2
New York	18,004	19,493	37,497	1,158	1,275	2,433	6.1
North Carolina	1,320	1,795	3,115	226	216	442	12.4
North Dakota	801	442	1,243	89	67	156	11.2
Ohio	6,370	5,568	11,938	644	546	1,190	9.1
Oklahoma	1,004	840	1,844	8	3	11	0.6
Oregon	1,422	783	2,205	78	115	193	8.0
Pennsylvania	5,100	4,148	9,248	322	271	593	6.0
Rhode Island	729	670	1,399	158	142	300	17.7
South Carolina	915	965	1,880	68	59	127	6.3
South Dakota	692	490	1,182	1	3	4	0.3
Tennessee	967	1,136	2,103	39	42	81	3.7
Texas	2,619	2,789	5,408	294	354	648	10.7
Utah	291	243	534	1	1	2	0.4
Vermont	338	354	692	9	.....	9	1.3
Virginia	2,125	2,102	4,227	339	313	652	13.4
Washington	2,113	1,295	3,408	243	144	387	10.2
West Virginia	977	831	1,808	216	254	470	20.6
Wisconsin	860	493	1,353	688	493	1,181	46.6
Wyoming	168	80	248	15	8	23	8.5

*Unascertained.

Table X—Increase in number of mental defectives in institutions in the several states of the Union, from January 1, 1910, to January 1, 1920, with rates per 100,000 of general population

STATE	Mental defectives in institutions						Rate per 100,000 of general population	
	January 1, 1910			January 1, 1920				
	M.	F.	T.	M.	F.	T.	1910	1920
United States	11,015	9,716	20,731	20,123	20,396	40,519	22.5	38.3
Alabama	.....	.....	.....	11	18	29	.....	1.2
Arizona	.....	.....	.....	18	14	32	.....	9.6
Arkansas	.....	.....	.....	75	75	150	.....	8.6
California	470	384	854	474	491	965	35.9	28.2
Colorado	39	25	64	163	102	265	8.0	28.2
Connecticut	156	138	294	247	221	468	26.4	33.9
Delaware	.....	.....	.....	.....	.....	.....	.....	.....
Dist. of Columbia	.....	.....	.....	5	1	6	.....	1.4
Florida	.....	.....	.....	79	73	152	.....	15.7
Georgia	.....	.....	.....	6	.....	6	.....	0.2
Idaho	.....	.....	.....	63	51	114	.....	26.4
Illinois	718	547	1,265	1,677	1,470	3,147	22.4	48.5
Indiana	518	617	1,135	582	682	1,264	42.0	43.1
Iowa	619	570	1,189	860	844	1,704	53.4	70.9
Kansas	237	183	420	359	372	731	24.8	41.3
Kentucky	167	116	283	337	304	641	12.4	26.5
Louisiana	.....	.....	.....	234	194	428	.....	23.8
Maine	49	13	62	229	203	432	8.4	56.2
Maryland	151	159	310	463	495	958	23.9	66.1
Massachusetts	879	585	1,464	1,678	1,514	3,192	43.5	82.9
Michigan	518	468	986	990	859	1,849	35.1	50.4
Minnesota	628	566	1,194	764	738	1,502	57.5	62.9
Mississippi	.....	.....	.....	79	57	136	.....	7.6
Missouri	233	279	512	525	522	1,047	15.5	30.8
Montana	30	21	51	86	44	130	13.6	23.7
Nebraska	235	211	446	359	323	682	37.4	52.6
Nevada	.....	.....	.....	2	.....	2	.....	2.6
New Hampshire	70	74	144	150	164	314	33.4	70.9
New Jersey	296	344	640	709	1,053	1,762	25.2	55.8
New Mexico	.....	.....	.....	.....	.....	.....	.....	.....
New York	1,685	1,736	3,421	2,660	3,102	5,762	37.5	55.5
North Carolina	.....	.....	.....	74	97	171	.....	6.7
North Dakota	79	66	145	118	96	214	25.1	33.1
Ohio	810	716	1,526	1,211	1,224	2,435	32.0	42.3
Oklahoma	.....	.....	.....	297	237	534	.....	26.3
Oregon	.....	.....	.....	216	259	475	.....	60.6
Pennsylvania	1,598	1,107	2,705	2,147	2,134	4,281	35.3	49.1
Rhode Island	48	.....	48	148	163	311	8.8	51.5
South Carolina	.....	.....	.....	85	70	155	.....	9.2
South Dakota*	.....	.....	.....	194	152	346	.....	54.4
Tennessee	25	22	47	83	86	169	2.2	7.2
Texas	9	10	19	70	154	224	0.5	4.8
Utah	45	.....	45	29	40	69	12.1	15.4
Vermont	.....	.....	.....	44	83	127	.....	36.0
Virginia	29	31	60	144	264	408	2.9	17.7
Washington	90	69	159	331	275	606	13.9	44.7
West Virginia	116	98	214	197	185	382	17.5	26.1
Wisconsin	468	561	1,029	760	864	1,624	44.1	61.7
Wyoming	.....	.....	.....	43	27	70	.....	36.0
U. S. Public Health Service hospitals	.....	.....	.....	48	.....	48	.....	.....

*No report for 1910.

Table XI—Neuropsychiatric patients in United States Public Health Service hospitals, January 1, 1920

HOSPITAL	Total	With mental disease	Epileptics	Mental defectives	Alcoholics	Drug addicts	Nervous cases
No. 1. Baltimore, Md	15	.....	1	2	.....	.....	12
No. 2. Boston, Mass	17	3	6	.....	.....	.....	8
No. 3. Buffalo, N. Y	3	1	2	.....	.....	.....	.....
No. 5. Chicago, Ill	20	2	1	1	.....	.....	16
No. 6. Cleveland, O	5	3	.....	.....	.....	1	1
No. 7. Detroit, Mich	13	4	2	.....	.....	3	4
No. 8. Evansville, Ind	2	.....	.....	1	.....	1	.....
No. 11. Louisville, Ky	5	.....	.....	.....	.....	.....	5
No. 12. Memphis, Tenn	5	.....	1	.....	.....	2	2
No. 13. Mobile, Ala	9	.....	2	4	.....	.....	3
No. 16. Portland, Me	1	1	.....	.....	.....	.....	.....
No. 17. Port Townsend, Wash	10	.....	1	.....	.....	.....	9
No. 19. San Francisco, Cal	4	1	.....	.....	.....	.....	3
No. 21. Stapleton, N. Y	21	9	1	1	2	.....	8
No. 22. Vineyard Haven, Mass	1	1	.....	.....	.....	.....	.....
No. 24. Palo Alto, Cal	29	.....	3	1	.....	1	24
No. 28. Dansville, N. Y	256	256	.....	.....	.....	.....	.....
No. 29. Norfolk, Va	1	.....	1	.....	.....	.....	.....
No. 30. Chicago, Ill	20	2	2	4	.....	.....	12
No. 32. Washington, D. C	5	.....	1	1	.....	.....	3
No. 34. East Norfolk, Mass	68	1	57	.....	.....	.....	10
No. 35. St. Louis, Mo	68	37	7	5	2	1	16
No. 37. Waukesha, Wis	90	3	.....	2	1	1	83
No. 38. New York City	17	.....	2	1	.....	.....	14
No. 39. Hoboken, Pa	274	261	1	5	.....	.....	7
No. 40. Cape May, N. J	140	46	2	14	.....	.....	78
No. 41. New Haven, Conn	22	6	1	6	.....	.....	9
No. 43. Ellis Island, New York City	30	29	.....	.....	.....	1	.....
No. 44. West Roxbury, Mass	58	42	4	.....	.....	.....	12
No. 45. Biltmore, N. C	8	1	3	.....	1	1	2
Total	1,217	709	101	48	6	12	341

ABSTRACTS

OUT-PATIENT PSYCHIATRY. By Abraham Myerson, M.D. *The American Journal of Insanity*, 77:47-74, July, 1920.

It is impossible in an abstract to give more than the merest outline of the valuable material contained in this article, in which Dr. Myerson discusses the data of the Out-Patient Department of the Psychopathic Department of the Boston State Hospital, from October 1918 to September 1919 inclusive. The questions that come up in connection with the work of the Out-Patient Department are grouped under four general heads: First, who sends the patients? Second, what problems do they present? Third, what are the diagnoses reached? Fourth, what is done with the patients?

The total number of new patients—adults, adolescents, children, and infants—received at the Out-Patient Department during the year in question was 1,577—664 males and 913 females. This preponderance of females over males Dr. Myerson considers a social rather than a biological matter. The excess of females occurs in the adult and adolescent classes, which are referable to two sources—the social agencies and psychoneurotics who come of their own initiative. As there are more social agencies interested in adult and adolescent females than in males of the same ages, more females than males are received from this source. Also, in the care of the psychoneurotics, more women than men have the leisure to come for treatment. On the other hand, the preponderance of male over female children—253 of the former to 148 of the latter—is in Dr. Myerson's opinion biological rather than social. "The preponderance is largely in the greater number of mentally deficient and delinquent boys sent in by the schools and the courts for examination."

Of the 1,577 patients, the greatest number—391—were sent by the social agencies, closely followed by those who came of their own initiative or through the initiative of relatives—301. One hundred and eighty-four (presenting mainly the problem of neurosyphilis) were sent by the Social Service Department of the Psychopathic Hospital, 165 from the wards of the Psychopathic Department, and 182 by physicians. The courts, the Red Cross, and the schools sent 80, 56, and 55 respectively; other hospitals 163.

As to the types of problems presented, the largest single group of cases was made up of the backward children, of whom there were 273. Next in numerical importance came the group of suspected insane persons (259) and the group of psychoneurotics (199). The

families of syphilitic patients in the wards of the Psychopathic Department made up another large group—170. Delinquents, after-care patients—mainly discharged from the wards of the hospital—epileptics, and cases of neurological condition were other types.

More detailed tables give the diagnosis and disposition of the cases from each source. In the groups sent by the courts, the schools, the social agencies, the Red Cross, and the other hospitals, mental deficiency held first rank; in the large group sent by the social agencies, over 50 per cent of the cases were suffering from some form of mental deficiency. There was little mental deficiency in the group sent by the doctors, which, since mental deficiency is largely a social problem, seems to indicate that the doctors are interested in the medical rather than in the social aspect of their cases. This view is borne out by the fact that the numbers of male and of female patients sent by the doctors were about equal. Nearly one-third of this group were cases of mental disease. The group sent from the wards of the Psychopathic Hospital was made up principally of patients who had been received as temporary-care or voluntary patients for a period ranging from 10 days to several months and then been discharged to the Out-patient Department as relieved or improved. There were 36 cases of dementia praecox in this group. This may seem curious in view of the present conception of dementia praecox as an incurable disorder, but is accounted for by the fact that in the majority of these cases the disease was not so marked as to make it no longer safe to allow the patient to remain in the community. Mental deficiency occurred only 5 times in this group; the majority of the cases of mental deficiency seen in the wards are either referred back to the social agencies that sent them or recommended to schools for feebleminded. In the group sent by the Social Service Department of the Psychopathic Hospital, consisting largely of families of syphilitics, 16 of the 184 individuals examined were cases of conjugal syphilis, a large number in view of the fact that the majority of the persons examined complained of no particular trouble. There were only 5 cases of congenital syphilis, which would seem to show that the danger to the wife is greater than that to the child. The cases that came through their own initiative or the initiative of relatives were largely psychoneurotics, the majority of them women, among them a noteworthy number of Jews. This Dr. Myerson attributes to the fact that the Jews are not afraid of the term psychopathic and, because of their intimate communal life, are more likely to send one another for treatment.

In closing, Dr. Myerson discusses, from the standpoint of the out-patient department, some of the types encountered there—the psycho-

neuroses, mental deficiency, delinquency—and makes a plea for the abandonment of the terms insanity and psychosis in medical discussions, as tending to obscurity. It would, in his opinion, simplify matters if each case were regarded from two angles—"First, what type of disease does this case present—feeblemindedness, hysteria, general paresis, dementia praecox, or anything else in the psychiatric classification groups; second, does this patient need commitment or can he be cared for in the community?"

THE CRIMINOLOGIST AND THE COURTS. By Herman M. Adler. *Journal of Criminal Law and Criminology,* 11:419-425, November, 1920.

Dr. Adler discusses here briefly three of the more important personality types encountered in the study of criminology—the paranoid or egocentric personality, the defective delinquent, and the psychopathic criminal—and some of the problems that come up in connection with them. Cases of these types will, in his opinion, present difficulties so long as the criminal law deals with them on the basis of responsibility and on the basis of property damage; they are personality problems and as such cannot be dealt with on the basis of property valuation. He recommends three changes in the present system of criminal law: 1. that criminals and delinquents shall be committed not to definite institutions, but to the guardianship of the State, to be under the scientific direction of trained criminologists; 2. that the treatment of prisoners shall be based upon a study of their individual needs, and that the duration of treatment shall depend upon their progress toward normality; 3. that criminals, feebleminded, insane, and dependents shall be legally declared minors until they are able to prove that they have reached a state of maturity equivalent to adult age and are capable of managing their own affairs.

THE EFFECTS OF SYPHILIS ON THE FAMILIES OF SYPHILITICS SEEN IN THE LATE STAGES. By Harry C. Solomon, M.D., and Maida H. Solomon. *Social Hygiene,* 6:469-87, October, 1920.

For the last five years it has been a routine procedure at the Boston Psychopathic Hospital to examine the families of all patients with a positive Wassermann reaction. Since this clinic deals primarily, not with syphilitics, but with cases of involvement of the central nervous system, practically all these patients have been late syphilitics. The patients were divided into three groups—cases of general paresis, of cerebro-spinal syphilis, and of late syphilis without involvement of the nervous system, this division being made

for the purpose of determining whether cases in which there is involvement of the central nervous system present a different family problem from those in which the central nervous system escapes. During the five years, 555 families have been thus examined. This paper is a thorough study of the findings of the examinations, from which the authors draw the following conclusions:

"1. The family of the late syphilitic abounds with evidence of syphilitic damage.

"2. At least one-fifth of the families of syphilitics have one or more syphilitic members in addition to the original patient.

"3. Between one-third and one-fourth of the families of syphilitics have never given birth to a living child. This is much larger than the percentage obtained from the study of a large group of New England families taken at random, which shows that only one-tenth were childless.

"4. More than one-third of the families of syphilitics have accidents to pregnancies; namely, abortions, miscarriages, or stillbirths.

"5. The birth rate in syphilitic families is 2.05 per family; whereas the birth rate in the New England families mentioned above is 3.8 per family, or almost twice as great.

"6. Two-thirds of the families show defects as to children (sterility, accidents to pregnancies, and syphilitic children).

"7. Only one-third of the families show no defect as to children or Wassermann reaction in spouse.

"8. About one-fifth of the individuals examined show a positive Wassermann reaction; more of these are spouses than children.

"9. Between one-fourth and one-third of the spouses examined show syphilitic involvement.

"10. Between one in twelve and one in six of the children examined show syphilitic involvement.

"11. One-fifth of all children born alive in syphilitic families were dead at the time the families were examined. This does not differ materially from the general average in the community.

"12. One-fifth of the pregnancies are abortions, miscarriages, or stillbirths, compared with less than one-tenth of the pregnancies in non-syphilitic families.

"13. The average pregnancies per family is 2.58, compared with 3.88, 4.43, and 5.51 in non-syphilitic families.

"14. There are 3.52 stillbirths per 100 live births in the syphilitic families, as compared with the 3.79 reported by the Massachusetts census, showing that there is no very marked difference in this regard.

"15. A syphilitic is a syphilitic, whether his disease is general paresis, cerebro-spinal syphilis, or visceral syphilis without involvement of the central nervous system, and the problems affecting his family are the same in any case.

"The family of every syphilitic patient should be examined, irrespective of the stage of the disease or the symptomatology presented by the patient when first seen. If this is done, cases of conjugal and congenital syphilis will be discovered which would otherwise be neglected. They will often be found at a period when symptoms are not active, and thus treatment may be instituted before irreparable destructive lesions have occurred. An opportunity is offered to prevent the development of such disabling conditions as general paresis, tabes dorsalis, aneurysms, and the like. The possibility of bearing healthy children may be increased. Every clinic dealing with syphilitic patients, whether it is primarily a syphilitic clinic, a neurological clinic, a cardiac clinic, or an internal-medicine clinic should be equipped with the machinery for bringing the members of the syphilitic's family to the clinic for examination."

THE AIR MEDICAL SERVICE AND THE FLIGHT SURGEON. By Lieutenant Colonel L. H. Bauer and Major William MacLake. *The Military Surgeon*, 46:40-50, January, 1920.

The establishment of the Air Medical Service as a separate branch of the Surgeon General's Office and the development of the medical officer known as the flight surgeon were due to a recognition of the fact that the medical problems of aviation are entirely different from those of any other service. The work of the Air Medical Service has three phases: (1) the selection of the flier, (2) the classification of the flier, (3) the maintenance of the flier. In selecting the flier, the standard physical examination for entrance into the army is not sufficient. Certain special tests of the eyes and ears are necessary to determine the presence of defects that are of slight importance in the case of a candidate for any other branch of the service, but that would seriously interfere with the efficiency of the aviator. These tests should be given, not necessarily by a specialist, but by a medical officer who has had special training in the making of such examinations. The same thing is true of the personality study that is made of each candidate, for the purpose (1) of detecting nervous and mental diseases that might render him temporarily or permanently unfit for the service; (2) of forming a definite idea as to how he will stand the strain upon arriving at the front; and (3) of determining and as far as possible compensating for the existence of latent tendencies that might become so accentuated, under the stress of actual

warfare, as to render him inefficient and increase the danger of a nervous and mental collapse. The vital importance of this personality study may be judged from the fact that, aside from the disability resulting from epidemics, probably 70 per cent of the cases of lowered efficiency among aviators are due to the condition called "staleness"—a break, either partial or complete, in the nervous system.

Classification of the selected applicants is based upon the results of tests with the rebreathing machine—an apparatus by means of which it is possible to determine the physical and psychological effects of a constantly diminishing supply of oxygen. The grading is into four classes: Class D are grounded as totally unfit to fly; Class C are allowed to fly up to 10,000 feet, Class B up to 15,000, and Class A to any altitude.

In the third phase of the work—the maintenance of the flier—the flight surgeon is the chief factor. He should himself be a flier and a specialist in the care of fliers, and he should live in as close touch with his men as possible, mingling with them at mess, in quarters, and during recreation time, studying them as individuals and becoming their confidant and adviser. He will thus be in a position to detect the first faint signs of lowered efficiency in his men and by treating them in time will often prevent accidents or serious breakdowns.

REËDUCATION OF DEMENTED PATIENTS. By W. A. Bryan, M.D. *The American Journal of Insanity*, 77:99-111, July, 1920.

For the past eighteen months the Danvers State Hospital has been carrying on an experiment in the rehabilitation of the class of chronic demented patients by means of occupational therapy. The experiment was undertaken on the theory that the degeneration of these patients to the filthy, destructive stage of their disease is largely due to habit deterioration, and that much can be done by special training either to prevent the formation of vicious habits or to form new and better habits in those who have already deteriorated.

The first step is the approach to the patient. This has been found to be largely a matter of trial and error. It consists of calling into activity some one of the following primary instincts—"play, imitation, acquisitiveness and constructiveness, affection, sympathy, self-assertion, curiosity, rivalry, pugnacity in certain cases, and occasionally the sex instincts, as expressed in modesty and vanity." The possibility of substituting one of these instincts for the more vicious instinct—fear, for instance—that is dominating the patient is the basis of whatever success is to be attained in the reëducation of

psychotic patients. The best opening is usually through the play instinct. "There are several reasons for this. It is accompanied by the emotion of pleasure, and thus is valuable in itself. It is stimulating to the imagination, thus developing intelligence, and by an almost imperceptible gradation it can be transformed into useful work without any diminution in the affective coloring."

In directing and modifying the patient's reactions to the newly stimulated instinct into new and better habits, to take the place of the vicious habits that have resulted from prolonged reaction to the old dominating instinct, certain important considerations must be kept in mind: (1) the incentive to the formation of the new habit must be strong as possible, varying according to the requirements of the individual case from judicious praise to the hope of additional privileges; (2) there must be no break in the regular routine by which the desirable habit is being established; (3) the work given to the patient must not be too difficult, since the stimulus of success is necessary to sustain his interest.

The latter part of the article is given up to an account of the practical application of these principles at the Danvers State Hospital. Emphasis is laid upon the necessity for using great care in selecting the instructors for this class of patients—since not every teacher of occupational therapy is qualified to handle them successfully—and for keeping the work purely therapeutic in character; "there should be no thought on the part of the instructors to produce objects that could be sold or even to make a great display." Dr. Bryan does not claim any wonderful recoveries as a result of this experiment in rehabilitation, but he does state that in every case there has been some improvement and that the work has come to occupy a definite place in the hospital's plan of treatment.

A Statistical System for the Use of Institutions for Criminals and Delinquents. By Horatio M. Pollock. *Journal of Criminal Law and Criminology*, 11:440-46, November, 1920.

The Committee on Statistics of the American Institute of Criminal Law and Criminology, in this, its yearly report, offers "a plan for the preparation of statistical data in institutions for criminals and juvenile delinquents." The formulation of a standard method of classification of the desired data was the first step necessary. It was decided that from the standpoint both of prison administration and of the welfare of the prisoner, the primary consideration is the prisoner's mental status. The first classification submitted by the committee is therefore as follows:

Mental Classification of Criminals and Delinquents

I. No demonstrable abnormality.

II. Mental deficiency:

1. Imbecile
2. Moron
3. Border-line

III. Mental disease:

1. Traumatic psychoses
2. Senile psychoses
3. Psychoses with cerebral arteriosclerosis
4. General paralysis
5. Psychoses with cerebral syphilis
6. Psychoses with Huntington's chorea
7. Psychoses with brain tumor
8. Psychoses with other brain or nervous diseases
9. Alcoholic psychoses
10. Psychoses due to drugs and other exogenous toxins
11. Psychoses with pellagra
12. Psychoses with other somatic diseases
13. Manic-depressive psychoses
14. Involution melancholia
15. Dementia praecox
16. Paranoia or paranoid conditions
17. Epileptic psychoses
18. Psychoneuroses and neuroses
19. Psychoses with psychopathic personality
20. Psychoses with mental deficiency
21. Undiagnosed psychoses

IV. Psychopathic personality:

1. Inadequate
2. Emotionally unstable
3. Egocentric
4. Others (specify)

Scarcely less important than the mental status of the prisoner are his behavior characteristics. These are made the basis of a second classification, as follows:

1. Emotionally unstable behavior
2. Profligate
3. Vagrant
4. Dishonest

5. Eccentric
6. Egocentric
7. Sexually abnormal
8. Others (specify)

A third classification valuable from the standpoint of prison administration is concerned with types of offenders. This includes four groups:

1. First offender
2. Accidental offender
3. Occasional offender
4. Habitual offender

The report includes also recommended forms of statistical data cards for the use of institutions in recording and reporting data concerning admissions, discharges, transfers, and deaths, with suggestions as to their use, and a list of the statistical tables that should appear in every annual or biennial report issued by institution or department.

THE STATE HOSPITAL PHYSICIAN IN RELATION TO CLINICS FOR MENTAL DEFECTIVES. By William C. Sandy, M.D. *The State Hospital Quarterly*, 6:77-81, November, 1920.

This paper, by the psychiatrist of the New York State Commission for Mental Defectives, emphasizes the point that the mental clinic "should not be regarded as a receiving station for the admission of mental defectives to institutions," but that on the contrary commitment to an institution should be a last resort. This attitude is essential, not only in fairness to the patient, but as a matter of expediency, in view of the limited institutional accommodations at present available. The clinic's study of an alleged mental defective, therefore, should include, besides the intelligence test, an examination for such physical defects as malnutrition, enlarged tonsils and adenoids, or defective vision or hearing, which might have resulted in retardation and apparent feeblemindedness. The neuropsychiatric aspect of the case also should not be neglected, since temperamental defects in an intellectually normal individual are sometimes mistaken for mental defect. Even after mental defect has been definitely established, institutional commitment is by no means always indicated. Many mental defectives of school age can be suitably provided for in special classes in the public schools; while for those of sixteen years or over, supervised parole can often be safely recommended, thus giving them a chance to perform useful work in the community and be-

come partially or wholly self-supporting. Commitment to an institution should be reserved for cases most urgently in need of custodial care or of training of a sort that cannot be provided elsewhere, such as cases of "continued delinquency and uncontrollable antisocial behavior, improper guardianship that cannot be corrected, or extremely low-grade mentality."

MORE ADEQUATE PROVISION FOR EPILEPTICS. By William T. Shanahan, M.D. *New York Medical Journal*, 112:879-84, December 4, 1920.

After a brief review of the present inadequate facilities for the care and treatment of epileptics in New York, Dr. Shanahan, Medical Director of Craig Colony, discusses some of the ideals that should be aimed at in establishing a colony for epileptics.

The site should be reasonably near a city or large town and sufficiently adapted to the buildings that are to be erected upon it not to require a great amount of preparation.

The first patients sent there should be capable of working regularly, except in the case of an occasional seizure, and should require little supervision. Patients who are so disabled physically or mentally that they cannot work and require a great deal of care are too heavy a handicap upon the institution in the early days of its existence.

The educational work should include not only the younger patients, but the older patients who were deprived of educational advantages in their younger years. Educational work with epileptics has a distinctly therapeutic value.

Extended classification of the patients—according to age, sex, grade of mentality, etc.—is of supreme importance. This will necessitate a number of small buildings instead of a few large ones.

As to size, a colony with a capacity for from five hundred to a thousand patients is recommended. A smaller colony than this cannot be so economically administered, while in a larger one it is difficult for the superintendent to keep in close personal touch with the patients and the activities of the institution.

The occupations offered the patients should be most varied. Work is a valuable means of treatment in the case of epileptics, often seeming to decrease the number of seizures and prevent mental deterioration. Farm and garden work are the most valuable forms of labor, both from the standpoint of treatment and that of financial return. In providing both occupations and recreations, the therapeutic aim of the institution should always be the first consideration.

A state institution, while it cannot be expected to provide the luxuries of life for its patients, should provide the essentials—

"proper housing, food, clothing, medical and nursing care, sensible hygienic methods as to bathing, recreation and other activities, with all reasonable opportunities for friends and relatives to visit patients, and assignment, so far as means permit, of compatible patients in each cottage."

Each patient should be allowed all the liberty that his condition warrants.

The village idea should always be foremost in the development of a colony, so that the stamp of the institution may be as much in the background as possible.

The salaries and living conditions of employees should be such as to attract desirable types of workers.

Institutions for epileptics should operate under a law providing that all mentally incompetent applicants be committed through a proper court, while applicants of normal mentality are received as voluntary patients, with the understanding that they may leave the institution upon short written notice.

The work of such institutions should include follow-up work and after-care of discharged patients and the dissemination in the community of information and advice concerning epileptics.

BOOK REVIEWS

THE PSYCHOLOGY OF FUNCTIONAL NEUROSES. By H. L. Hollingworth. New York: D. Appleton and Company, 1920. 259 p.

Students of mental phenomena are divided, to-day, into two schools or camps with markedly contrasting viewpoints and methods. They are psychopathologists and what we may term "academic psychologists." The former observe abnormal psychic reactions, endeavor to reconstruct the functions thereby analyzed and thus arrive at some knowledge of the normal, which is too complex to be understood in its complete integration. This is analogous to the method of experimentation which has advanced the science of physiology in the last forty or fifty years. The academic psychologists, on the other hand, first worked by introspection and more recently by measurements of normal function. (A third school, that of the behaviorists, might be mentioned, although their methods and viewpoint are not germane to the present discussion. They examine such primitive reflexlike behavior as is common to man and animals and assume that a complication of the simple mechanisms observed may produce the elaborate mental behavior of the adult man.) The material suitable for both introspection and measurement is limited to the static functions of sensation and intelligence, and the academic psychologists have taught us much that is essential about perception, attention, retention, apprehension, etc., as well as the capacities of the special senses. The psychology of the emotional part of lives, however, of the power of certain ideas, of instincts, of the origin of our feelings, and so on—all this is too elusive for introspection and incapable of measurement, but is capable of analysis in pathological conditions. The two fields of research have no immovable fence between them, but they are essentially different. There should, therefore, be no antagonism between these different groups of workers, yet, with a few brilliant exceptions such as William James, Stanley Hall, and Lyman Wells, the academic psychologists have apparently been jealous of the psychopathologists. They have ignored the latter's material and disputed their claims often with vituperation. Resentment has not been wanting.

Yet there is common ground in which each school can aid the other. This is in the study of the social and individual problems arising out of the abnormalities and subnormality of the intellectual functions. In recent years the psychologists have done invaluable work with the feebleminded by measuring their intelligence and thereby regulating the educational and industrial demands made on these unfortunates. This advance, however, has not been achieved without sacrifice, for this method of research is fraught with danger. The human mind

loves the concrete and obvious. Compare the popularity of Charlie Chaplin and Forbes Robertson. In the scientific world—particularly in the present phase of intellectual evolution—there is a love for that which can be measured. The more intricate and baffling a problem, the more firmly do we cling to such aspects of it as are capable of mathematical representation, thereby protecting ourselves from the uncomfortable feeling of ignorance. The method of academic psychology having contributed to the knowledge and treatment of feeblemindedness, there has been a strong tendency for the proponents of this work to claim that their methods will solve all, or many other, human problems. Thanks to the universal satisfaction in the concrete, the uncritical public have been largely impressed with these claims. Hence little outcry arises when statements are made such as that all prostitution or all crime is due to mental defect because some considerable number of wayward women and jail inmates grade low on a Binet scale. Yet a moment's consideration shows that conduct is determined by desire and that what we want is not nearly so much a matter of intelligence as if it is of emotion. To take a glaring example, the man in high office who elopes with another's wife does not do so because he is stupidly unaware of the consequences, but because he wants her more than he cherishes his good name. The defective criminal may be less capable of calculating his sacrifice and his poor intelligence may restrict the field of his desires, but his craving for the unlawful is, of itself, as purely an emotional thing as is the lust of the gifted reprobate. Psychometry—the science of intellectual measurement—can therefore make only indirect contributions to the study of conduct or of the emotions generally.

This tedious introduction has been necessary in order to explain the space given to review of the book before us. Its importance lies not in its absolute worth, but in its being representative of the work of a school whose claims receive more attention than the facts perhaps warrant. The war neuroses presented problems of equal military and medical importance. In the A. E. F. these casualties were treated by psychopathologists who regarded the conditions as purely emotional in origin and achieved brilliant therapeutic (and military) results by working on this basis. A small number of these cases were returned to this country and, relatively speaking, a handful of these were examined by the author. On the basis of his observations he presumes to outline a theory for all psychoneurotic reactions. It should be added that he presents no evidence of prior contact with any psychopathological material and that he has had no medical education.

It is often stated that theories pass through three stages of recognition. First they are ridiculed, secondly an admission is made that

there is something in them, and finally the claim is made, "We always said so." Many academic psychologists have passed through the first two stages in regard to psychopathological theory, and Professor Hollingworth has just launched himself into the third. He takes a fundamental concept, common to both the psychology of Freud and Prince, gives it an old name, and denies any value to the work of the psychopathologists. This concept is that symptoms arise as reactions to past experiences of a complex nature, the present stimulus representing only a part of the original experience which is not recalled in its entirety. To quote the author, "Redintegration is to be conceived as that type of process in which a part of a complex stimulus provokes the complete reaction that was previously made to the complex stimulus as a whole . . . A child is frightened by a large, black, growling and moving quadruped. Both stimulus and reaction are complex. On a later occasion the growl alone provokes the entire fright reaction, even when made by a parent crawling on all fours, or hiding behind the door." This term of "redintegration" he takes from Hamilton, who used it for something analogous yet different, namely, "the tendency of a complex idea to be reinstated upon the occurrence of one of its constituent parts." In Hollingworth's "redintegration" only the reaction to the original idea recurs, *not* the idea itself.

The redintegrative response, he says, may take place on any one of three levels. On the normal or "cortical" level, a train of thought is set up by the stimulus which leads to complete memory of the original situation and a reasonable response. On the "spinal" or "postural" level, movements or attitudes of fight, defence, aggression, etc., take place which are appropriate to the original, but not the present stimulus. On the "automatic" level, smooth muscle, visceral and glandular reactions are set up which appear in consciousness as emotional feelings. Uninhibited "spinal" reactions give hysterical symptoms, the "autonomic" such emotional states as appear with pathological anxiety. Successful cortical redintegration inhibits or modifies the other two so that the whole reaction is not abnormal. Fundamental problems of psychiatry are neatly solved and disposed of in the following sentence: " . . . if there is an attempt to rationalize this experience (insistent fear, worry or dread) of the fixated autonomic response, this leads to the pictures of melancholia, paranoia, or the compulsive neurosis, depending on the nature of the emotion and the other characteristics of the individual." Only prolonged thought can give a psychiatrist an idea of the enormity of ignorance displayed in this quotation.

This theory—or rather description of phenomena demonstrated daily—implies the existence of an unconscious idea. If I am frightened

by a bull, and later get the same fear reaction when I see a piece of horn lying on the table, although I do not think consciously of the bull, I must have an *unconscious* image of the charging beast in my mind. Hollingworth states plainly that these abnormal reactions do not take place when complete awareness of the memory is present (pp. 74, 75), but only when the subject is unaware of the effective stimulus. If there be memory of an idea, the memory be stimulating some reaction, yet the subject be not conscious of the idea, surely this memory is unconscious. Yet Hollingworth attempts to drown this conclusion in the following verbal cataract: "A special merit of the redintegrative concept is to be found in the ease with which it dispenses with the elaborate fiction of the efficacious unconscious. Therapeutic attempts would presumably proceed with equal success on either hypothesis. The one hypothesis, however, flagrantly and naively ignores the familiar canons of demonstration and proof, while the other seeks to articulate itself in an intelligible fashion with the ordinary psychology of the accessible."

Those whose profession it is to analyze the mental mechanisms of neurotic symptoms find these "redintegrative" phenomena universal and are forced to adopt the working hypothesis of an unconscious mind not merely because the facts imply it, but because it explains the ignorance of the patient as to the cause of his reactions. Forced to substitute something for this hypothesis, if he is to publish anything new, Hollingworth suggests that the ignorance is due to a lack of sagacity, in other words, that the psychoneurosis is related to feeblemindedness. That he means this seriously is shown by the fact that he spent much time in efforts to prove the defect and has written a book about it.

It is, of course, an easy matter to show on the basis of clinical material that the factors entering into psychoneurotic reactions are emotional rather than intellectual, but the demonstration would be tedious and most readers are quite conversant with it. But it may be interesting to examine Professor Hollingworth's work, since evidence of a universal mental defect among psychoneurotics would force us to consider it as at least a contributory factor in the production of neuroses.

His chief findings are epitomized in the following table,[1] which is made up by appending the average mental ages from Table IV to Table III (pp. 87 and 88). The table shows in each clinical group the number of cases who passed the tests for the mental ages recorded in the first column.

[1] There are several inconsistencies in this table, but it is published as it appears in the book.

	Mental Deficiency	Epilepsy	Hysteria	Constitutional Psychopathy	Neurasthenia	Psychoneurosis	Concussion	Psychasthenia	Cerebro-spinal Meningitis	Organic Conditions	Psychoses	Undiagnosed	Totals
Failed . . .	3	28	15	2	5	9	1	0	0	5	1	18	83
5- 6	2	1	2	0	0	0	0	0	0	0	0	2	7
6- 7	1	4	5	0	0	1	0	0	0	0	0	3	14
7- 8	6	12	10	2	1	8	2	0	0	0	0	9	50
8- 9	13	36	15	5	6	7	1	0	0	2	3	17	105
9-10	5	36	19	5	7	9	3	0	2	3	1	24	114
10-11	9	31	14	7	8	7	7	1	1	4	2	25	116
11-12	0	35	16	6	11	16	6	1	2	7	1	31	133
12-13	1	35	16	5	6	9	3	1	6	7	0	19	108
13-14	0	29	15	2	11	10	4	2	2	4	1	18	98
14-15	0	22	11	3	8	10	3	1	5	4	1	21	89
15-16	0	15	13	1	3	6	3	1	1	1	1	13	58
16-17	0	31	16	5	10	11	6	2	3	6	2	20	112
17-18	0	16	7	5	1	6	2	0	2	5	3	5	52
18-	0	8	3	0	6	5	0	1	2	1	0	7	33
Total . .	40	339	177	48	83	114	41	10	26	45	16	232	1172
Average mental age	9.0	12.0	11.9	12.5	13.0	12.6	13.0	14.9	14.6	14.0			

An examination of these figures shows that only 384 cases were diagnosed as hysteria, neurasthenia, psychoneurosis or psychasthenia. The others were not neuroses at all, yet he not only prefaces his book with the promise of examining some 1,200 neurotics, but in many of his arguments deals with the mental endowment of his total material as of "psychoneurotics."

Let us examine these figures more in detail.

The average mental age of all the psychoneurotics turns out to be 12.4. The average mental age of recruits sent to France was 14.0, so that these psychoneurotics were on the average developed intellectually 1.6 years less than their fellows. Unfortunately for the validity of these figures the author has added material of interest to the special technicians of psychometry, which, though irrelevant to his thesis, gives data of use in criticising his results. The first had to do with "scattering" in the performance of the mental tests, that is, the tend-

ency to perform better in some tests and poorer in others rather than to show an even efficiency on all tests up to a certain age level. Scattering has long been recognized as a characteristic of psychotic rather than of feebleminded patients. It is apparently due to variations in interest, attention, inhibitions, etc., which are incidental to the disease of the patient. Hollingworth found that his material showed a marked tendency to scattering, particularly in the hysteric group. Now it is theoretically impossible for any one to exceed his native intellectual capacity; hence all deviations must be the result of indifference or inhibition that tends to rate lower than his actual intellectual endowment would justify. Consequently we are justified in adding the difference between the average deviation of the psychoneurotics and the average deviation of the feebleminded to the average age determined for the psychoneurotics in each group. For instance, the average deviation of the hysterics was 2.0 years and of the feebleminded 0.9 years. The difference of 1.1 years added to the average mental age of the hysterics brings it up to 13 years. Similarly the neurasthenics reach 13.7 and the psychoneuroses 13.3.

A second defect in his method which the author unwittingly exposes has to do with the type of tests employed. All of the cases were examined by "group surveys" where the intelligence ratings of newly arrived patients were made in batches. Only in some 93 instances were these controlled by individual examinations. In order to test the reliability of these group surveys the results in the 93 cases were compared with the findings of the initial examinations of the same patients. An average difference of 1.3 years was discovered, which usually ranked the patient higher in the individual than in the group test. Of course since the examination of recruits was made by the group-survey method, this difference would tend to indicate a somewhat higher standard than 14.0 years, just as it would elevate the ratings of the psychoneurotics. But as the latter are more apt to need individual encouragement to put forth their best efforts, it is safe to assume that individual tests on these 384 cases would have rated them relatively higher than they are represented.

Taking these two factors into account, we are probably right in believing that in the most defective of Hollingworth's patients (the hysterics) the actual defect demonstrated is, on the basis of his tests, less than one year's development behind the average of the army. Nevertheless this is something and he has also shown a relative inferiority of the hysterics as compared to the other groups. How can the slight defect be accounted for? Those who were in the Neuropsychiatric Service in France know the answer well. Up to the time of the armistice only those psychoneurotic cases who showed severe symp-

toms in spite of careful and expert treatment were evacuated to the United States. They were mainly cases who had been abnormal prior to enlistment, but had escaped the scrutiny of the draft boards. From the beginning of the St. Mihiel offensive to the armistice they were only 1 per cent of all the neuroses arising in battle. During the same period 11 per cent of the cases recovered sufficiently to be returned to duty behind the lines as B and C class men. It was not until well towards the end of 1918 that these B and C class patients began to be evacuated to America. Since it took a full month on the average for a soldier to reach Plattsburg after leaving France, it is impossible that Professor Hollingworth saw much more than the 1 per cent before his work finished at the end of January, 1919. These were the dregs, as it were, of the neuroses. They were the rank failures. Now if one examines 100 failures in any jail, poorhouse or asylum and also 100 men picked at random from the community at large, he will find that the former are inferior to the latter. This inferiority will show itself in a high rate of deformities, "stigmata of degeneration," feeblemindedness, emotional instability and personality defects. Not one of these things is specific, but the statistics will be imposing. Another observer could probably have taken Hollingworth's material and shown with equal force that the war neuroses were due to adherent lobules of the ear, high palates, asymmetric faces, misshapen heads, and so on. There were some 11,000 neuroses in France that developed under highly unusual circumstances. The author saw 384 cases culled so as to eliminate the typical ones. He examined these in wholesale lots, retired with his examination papers and writes the *Psychology of Functional Neuroses.*

Before leaving the subject of the alleged intellectual defect of these cases, a word should be said as to the value of statistical studies in material of this sort and as to the reliability of his tests. If 75 out of 100 men should admit that they no longer loved their wives, could any one then claim that the average American is one-quarter in love with his wife? In problems of this order essential factors must be present in every case or they are not essential. If 99 out of 100 hysterics were demonstrably feebleminded, the presence of normal intellectual capacity in the one-hundredth would show that the defect was not essential, but only a contributory factor or a coincidence. From his own tables it appears that some hysterics were above the mentality of the average soldier. From the fact that the psychasthenics were above the average (and that those with subjective and emotional symptoms were generally of superior intelligence) he argues that this neurosis affects those of superior intelligence *in virtue of that intelligence,* speculating much as to how this comes about. From the table above one sees that 2.6 times as many cases of cerebro-spinal

meningitis were also more gifted than the average soldier. Did intelligence also produce meningitis?

The book is full of such pointless statistics, in fact the author admits in some cases that the significance of them is not clear. One chapter is devoted entirely to tables showing the geographic origin of his patients, their trades, etc., all of which are as instructive as data would be which they might supply as to their clothes in civilian life.

Then as to his tests. Hollingworth is much interested in the fact that the psychoneurotic cases tended to group themselves around the age levels of the eleventh and sixteenth years. These "modes" show, he thinks, that both superior and inferior intelligence tend to produce or perpetuate neuroses. To the reviewer a simpler explanation seems probable. All his groups, including organic nervous diseases and meningitis, showed this bimodality. If the organic cases show it, normal people will too, and, if that be the case, the tests are not properly standardized.

In his zeal to make out a case the author has scanned the literature to find confirmation of his claims. One author speaks of 90 per cent of cases showing a constitutional predisposition, mainly of the schizophrenic and defective group. Another says frankly that the majority of the patients are below the average of mentality as measured by the Binet-Simon scale. Otherwise he has no support. But he endeavors to twist innumerable reports of *relative and general inferiority* of hysteric to anxiety patients into the statement of absolute intellectual defect. When these authors speak of the development of hysteric conversion symptoms being favored by ignorance of physiology, he asserts that their poor education is the result of feeblemindedness. If that be the case, there must be infinitely more feeblemindedness in Europe than America, for civilian hospitals receive many hysterics in England and the Continent, while they are quite rare in this country. Jingoes would enjoy this conclusion more than statisticians. That ignorance is not feeblemindedness is shown by Professor Hollingworth himself, who consistently writes of concussion as a psychoneurosis.

The style of the book is generally readable, if a little difficult at times, the obscurity being increased by the use of esoteric technical terms. Apparently the work is intended for eyes of laymen, yet we find such a sentence as this: "The semi-interquartile range of both medians is 2.5 years." None of these terms is anywhere defined. Ignorance of common psychiatric facts, even of the meaning of simple diagnostic terms, appears every few pages.

That scientifically this work is valueless is clear; that, if read uncritically, it may be pernicious is probable. But does the mischief

end there? Our soldiers are sent to hospitals, like our civilian patients, to be treated, not to be investigated in the interest of preposterous hypotheses enumerated by ignorant laymen. Proper reëducation, says our author, "is possible only after a careful psychological inventory of the patient's capacities and disabilities." In the A. E. F., without the benefit of such technique, 99 per cent of cases were returned to duty and 88 per cent to combatant duty. What is the effect of "psychological" examination and treatment on the neurotic? One would suspect them to be irritating. At least we have this picture of what Professor Hollingworth considers the normal atmosphere of a hospital for neurotic soldiers to be:

"As a result of these various factors, in a military hospital, where detentions are not voluntary, and especially in a hospital for functional conditions as distinguished from the psychoses or insanities, a recognizable atmosphere develops, which combines with the original mental makeup of the incoming or resident patient to produce an attitude of indifference or of overt hostility. There is an indefiniteness of personal aim and endeavor and a general resistance to diagnosis, treatment and rehabilitation."

In contrast to this let us consider the following: In the early years of the war the British government discharged with pensions many neurotic soldiers as incurable. Later some of these were sent by the Ministry of Pensions to a special hospital manned by psychopathologists. Of these chronic patients, faced with a loss of or reduction of their pensions on recovery, 90 per cent were well enough to seek employment in six weeks. In the spring of 1918 abolition of the hospital was threatened. Unknown to the staff the patients sent a petition to the government, unanimously signed, praying that their treatment might be continued and the institution preserved for their own good and that of their fellow sufferers. Does "psychological" investigation produce this attitude?

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THE TECHNIQUE OF PSYCHOANALYSIS. By Smith Ely Jelliffe, M.D. New York and Washington: Nervous and Mental Disease Publishing Company (Series No. 26), 1918. 160 p.

This is the first book that has appeared on the technique of psychoanalysis. In seven chapters the author discusses briefly the material to be analyzed, the literature, sources, and history of psychoanalysis, the opening, general situations, and preliminary formulations of the analysis, the Œdipus hypothesis, transference and resistance, over-

coming of the conflicts, socialization of the personality, and use of the dream.

The author tells us that he writes for the neophyte, but many others have read and will read this book on account of the wealth and extent of its intellectual interests. One follows captivated the luxuriant phraseology and abundance of inspiring quotation. The book is difficult to review, however, on account of its discursiveness and circumstantiality. It is hard to convey to the reader the many flashes of light which the author throws upon the incidentals of analysis, for they flash up here and there, not always with direct relevance upon the subject of discussion.

His description of analysis is good: "Psychoanalysis is primarily to be considered as a method. As such it seeks to establish a knowledge of the development of individual human motives. Just as a chemical analysis serves to determine the ultimate composition of this or that substance present in nature, so psychoanalysis has for its task the unraveling of the ultimate composition of this or that manifestation of human conduct. Psychoanalysis, then, is merely a tool, just as chemical analysis is a tool—both are methodological disciplines working with different facts of nature, each seeking to determine ultimates in their respective spheres; the former dealing with data of that portion of the nervous system functioning to adapt the individual and the race to reality, the latter working with the inorganic and organic substances making up a large portion of that reality."

Every one who has had experience with the futile methods of the older schools will be pleased with the exact and brief summary of their lack of results: "For many years official psychology was limited to the so-called physiological psychology. This was practically little more than a detailed physiology of the sense organs. Its study developed a mass of information relative to the receptors and the conducting mechanisms of the special sense organs, facts of great importance, but of little practicability in getting at explanations for human conduct.

"Another important attitude of psychology was its insistence upon what it was pleased to call its 'norms.' The famous dictum that the abnormal in mental life could only be understood from a study of the normal has been one of the chief obstacles to progress. Such an attitude of mind could only have come from the laboratory worker unacquainted with the progress made in the chief biological sciences. For here the great advances in knowledge have come from the pathological side. The normal has been built out of the pathological. Hence when Freud, rejecting all of the dicta of the official and reign-

ing schools of thought, constructed his psychoanalytic method upon pathological data, he followed the path of experience in the other biological sciences, and by avoiding the sterile psychology of that fatuous nonenity 'the normal mind,' founded a method of great value. . . . I think I may say that practically every philosophical hypothesis, save pragmatism, has neglected what are called pathological data, overlooking the fact that pathological does not mean of a different qualitative nature, but simply a variant which must be measured by the same standards as that which is called normal."

The following cannot be emphasized too much: "It is highly advisable for the analyst to point out that his treatment is exclusively medical, and that it is not metaphysical or mental healing, nor anything of that ilk. It is medical sense applied to particular types of problems." The author thus agrees with Freud and his pupils that medical psychoanalysis is primarily a part of psychiatry, and one regrets that he does not adhere to this view in actual practice.

The author adopts the conception of three levels of human reaction —the bio-chemical or vegatative; the sensori-motor reflex or physiological; and the psychical or symbolic, representing reactions of the individual as a whole to the environment. For purposes of psychoanalysis, he divides the patient's life into three periods of growth: "From conception to birth; from birth to five years of age; and from five years of age to adulthood; each of these represents a wonderfully elaborate scheme of reliving the past through a masterful *recapitulation.*"

In the last chapter, his diagrams, schematically representing fixations of libido, unconscious trends as shown in the dream wish, and gradual transformation of the primitive wish as it passes to conscious expression in the dream, are very acceptable; for they bear witness to the way one tends to image personal energy processes after much working with analyses. These diagrams represent developmental levels as well as different areas of libido distribution. Dr. Jelliffe calls the processes, proceeding in order from below upward, the archaic, the auto-erotic, the narcissistic, and the social.

His diagram on page 40 aims to show the first steps in libido distribution following birth and divides the sensory areas into respiratory, nutritive, skin structures, pelvic, and special senses. This scheme allows a more extensive system of terms for discussing the patient's symptoms; but when the author states that "each and every libido area here represented is a compound which analysis endeavors to resolve," the reviewer is thrown into a quandary, for naturally an analysis would take him back to more fundamental libido values. If, however, he endeavors to follow the differentiation and devolopment of

these libido values forward into the patient's present condition, he is either following a preconceived theory of racial development and not the patient's individual psychic history, or he has already analyzed the patient's present into these compounds." In neither case is analysis resolving the compound.

One must read the book to appreciate the original and stimulating viewpoint of the author. His technique is his own and does not pretend to be Freudian. He says, "The present series of articles is planned for the beginner in psychoanalysis. They therefore will contain little which the trained analyst does not already know." But in fact they contain much more than he knows, and any one seeking information about technique is more impressed with the fascinating qualities of the author's mind than with what he finds to aid him. A great many of his explanations are confusing to the neophyte, and even the Freudian initiate must stretch them considerably in order to make his meanings clear. This is due to the fact that this technique which does not pretend to be Freudian is nevertheless constantly working with Freudian mechanisms. The experienced analyst must often try hard to forget Freud in order to follow the author.

Although understanding the limitation of definition in dynamic work, the author seeks to give a very exclusive definition of *sexual:* "In this present volume . . . *sexual* means any human contact actual or symbolic by means of any sensory area with the object of the same or of the opposite sex which has *productive creation* for its *purpose,* be it concretely in the form of a child or symbolically as an invention, artistic production, or other type of mutually creative product. It does not apply to those contacts which have purely nutritive or self-preservation instinct behind them. And it does not apply solely to genital contacts." This certainly helps us to make a distinction between intentionally productive and other forms of sexual relation, and consequently suggests a basis for determining conscious social values with regard to sex. It starts a stream of questions, however, about where one should catalogue various other forms of sex activity; and it renders the situation less clear, to make these rigid distinctions, than to allow the word its alimentary and genito-urinary inclusions, as does Freud. It is much less confusing to think of the whole libido as having evolved from polymorphically partial trends and to make the sexual the central dynamic according to Freud: this sexual, as far as genital demonstrations are involved, becoming at times extremely attenuated almost to the vanishing point and transforming into other expressions of creative energy; and at other times becoming obviously related to what we ordinarily call sex. Even the desire for self-protection or for money or for power is an urge toward

expressing the life energy. Whether or not this energy is blocked in self-love as distingushed from object-love depends upon much which Dr. Jelliffe does not attempt to discuss.

In the chapter on *Transference and Its Dynamics,* we are introduced to much interesting psychological literature on various subjects.

Occasionally we get flashes of the author's originality: "The physician is a projected wish of the individual's own unconscious. The physican becomes the agent whereby individual immortality may possibly be accomplished. Medicine in its broadest bearings is the projected wish of the community to insure its continuance."

Another keen and interesting idea must be quoted: "It must be borne in mind by any one who is working with psychic material that fundamentally people are much alike; the unconscious, containing a racial recapitulation (inheritance) of one hundred million years, is very much on a par all around.

"I frequently illustrate this to my patients by saying that the entire active life of the indivdual may be represented by a fraction, the numerator of which is any particular moment, the denominator is the rich inheritance of the past. Psychology and most reasoning has heretofore concentrated its attention on the numerator, and has made it appear to be the active life. Conscious knowledge has been made this, the criterion of man's entire activity. The denominator, which is infinitely more extensive and more important, is either neglected entirely or vaguely spoken of as intuition, instinct, temperament, personality. . . ."

If the chapter on *Transference and Resistance* has a fault as a whole, it is that the tenderfoot in analysis for whom the book is written is led to pay too much attention and become too conscious of his own sex, not in Dr. Jelliffe's, but in the layman's sense, and thus he interferes with the psychoanalytic work of liberating the patient from conflicts. It evinces a sex sensitiveness.

This book of 160 pages (not including a preface of two and an introduction of six) contains a great number of abstracts and direct quotations from psychoanalytic authorities, principally Freud, Rank, Ferenczi, Abraham, Reik, Silberer, Maeder, Jones, and it is often hard to tell whether the author is speaking of his own interpretations or of those of others. The quotations from Freud (p. 94) are really no quotations in the exact sense of the word. The author constructed new paragraphs out of passages taken here and there from Freud's very serious paper, and thus often produced "paragraphs" which at best are clumsy and do not exactly reproduce the original.

The chief motive for writing the volume is summed up by the author himself: "I have tried to show the value of a participation on the

part of the physician and patient in the greater cosmic view both of the origin and development of that unconscious which must be investigated, as well as its potentiality for the future of the race. There is necessary likewise the detailed appreciation of the individual effort to realize his position in society, his failure or success in handling the forces within him, and the guiding of his libido trends into a successful adaptive relation to cosmic progress." And the purpose has been accomplished.

The book is very illuminating and interesting for those who are well acquainted with psychoanalysis. As a technique for beginners its value is questionable.

A. A. Brill.

New York City.

Taboo and Genetics. By M. M. Knight, Iva L. Peters, and Phyllis Blanchard. New York: Moffat, Yard and Company, 1920. 301 p.

The study of the foundation of the family is approached from three directions by three separate authors. *The New Biology and the Sex Problem in Society* is written by M. M. Knight, *The Institutionalized Sex Taboo*, by Iva L. Peters, and *The Sex Problem in the Light of Modern Psychology*, by Phyllis Blanchard.

The first part, dealing with the biology of sex, is well done and contains a great deal of information of interest and importance in approaching the larger social problem. There is an interesting discussion of the nature of sex and its basis in the sex chromosomes. The work of Dr. Lillie on the Free-Martin and Bell's work on the Sex Complex are interestingly reviewed in relation to the question of intersexes and the masculine and feminine components of character. Ward's "gynaecocentric" theory is discredited.

In the second part the whole question of sex is taken up with reference to taboos and in it is shown how sex taboos, which have survived their usefulness, continue to dominate beliefs, customs, and institutions. There is a very interesting discussion of the ambivalent attitude toward woman as saint and witch.

The third part discusses the directions in which development of ideas and practice regarding sex seems to be tending, and is in general a plea for an extension of the field of conscious control, and a replacement by control of prejudice and taboo. There is an excellent discussion of the needs of the individual versus the needs of the community, and a very suggestive interpretation of some of the present difficulties as based upon an arbitrary standard of masculinity and femininity. The author feels that it is essential for the welfare of the

race that social premiums and standards should be so changed as to make it to the advantage of the superior stocks to reproduce.

WILLIAM A. WHITE.

St. Elizabeths Hospital,

THE NEW PSYCHOLOGY AND ITS RELATION TO LIFE. By A. G. Tansley. New York: Dodd, Mead and Company, 1920. 283 p.

This book contains thirteen chapters in which the author aims to present in a comparatively short space, and without employing more than the most essential technical terms, a fairly comprehensive sketch of the vital characters and activities of the mind. The book is divided into six parts: an introduction dealing with the new psychology, and the physical and psychical worlds; the structure of the mind; the energy of the mind; byways of the libido; reason and rationalization; and the contents of the mind.

The book has fairly fulfilled the purpose for which it was written. But the exposition of the new psychology is not really clear, and can be comprehended only by those who know their way about in the subject. No one school of thought has been followed exclusively, so that gaps and inconsistencies appear in the presentation of the subject as a whole. The author's application of the new psychology in its relation to life is very disappointing in that he brings out nothing essentially new nor is his application especially convincing.

One great fault in books of this type is the absence of apt clinical illustrations. Secondly, they should be written by medically trained minds—an absolute necessity if we are to get anywhere in a special field of medical science in which there is so much difference of opinion and method of approach. So far as a thorough exposition of the essential nature of the new psychology is concerned, with clearness of presentation, Freud's most recent work leaves nothing wanting. The application of such principles to problems of life could hardly be better presented than by White in his various writings which are those of a well seasoned psychiatrist. Even in the preface the author's use of such terms as "madman" and "lunatic" shows the possible gain of rhetorical effect at the expense of a more humane or scientific use of terms. No psychiatrist would strive for such an effect at the expense of the gentler minded.

Finally, one may say that the whole subject is so involved that even the trained worker can hardly discover the fundamental conception of the author by his use of the term "primary unconscious" as being quite distinct from the "Freudian unconscious." Had the author been able to devote his entire book to the latter object of his

study, he might have been able more fully to expound that phase of his subject. But have we sufficient data as yet, beyond the purely personal uses of the new psychology, to formulate very exact and full applications of these principles to the broader and general uses of society?

L. Pierce Clark.

New York City.

The Group Mind. By William McDougall, F.R.S. New York: G. P. Putnam's Sons, 1920. 418 p.

Sociologists may have found the author's *Introduction to Social Psychology*, which was published in 1908, unsatisfactory because of its too exclusive preoccupation with psychology, but to the student of human nature that truly noteworthy and original contribution has been an inexhaustible source of inspiration and guidance. It is therefore doubly disappointing to find the author's latest book, *The Group Mind*, so wholly devoid of any reference to the very worth-while contributions to the study of human nature in its individual and collective manifestations that have come to light since 1908.

If one were to insist that no worth-while book on the group mind could be written without reference to the contributions of Freud, Trotter, Graham Wallas, and others who have concerned themselves with the dynamics of collective thought and action, it does not necessarily mean that one is wholly in accord with these writers. Whatever one's attitude may be to the Freudian psychology, the conviction is no less genuine that such concepts as those of the unconscious, the censor, repression and projection, the wish element in human action, and Trotter's treatment of the herd instinct cannot be ignored in any discussion of collective psychology.

Neither can one ignore in a work of this kind the concept of "balked disposition" which economists have found to be fruitful in explaining some of the outstanding phenomena of group psychology. McDougall, however, seems to have taken special pains to avoid any of these concepts in his discussion of the group mind. If this omission was prompted by a desire to avoid distraction from the author's main thesis, it has, we fear, not resulted in the kind of clarity of presentation that would leave the reader with some sort of clear-cut conception of the group mind. The essential theme of the book, as set forth by the author, is: "The resolution of the paradox that while participation in group life degrades the individual, assimilating his mental processes to those of the crowd, whose brutality, inconsistency, and unreasoning impulsiveness have been the theme of many writers, it is only by participation in group life that man does become fully

man. Only so does he arise above the level of the savage." The book, in the author's words, examines and fully recognizes the mental and moral defects of the crowd and its degrading effects upon all those who are caught up in it and carried away by the contagion of its reckless spirit. It then goes on to show how organization of the group may and generally does in a measure counteract these degrading tendencies and how the better kinds of organization render group life the great ennobling influence by the aid of which alone man rises a little above the animal and may even aspire to fellowship with the angels. So much for the aims of the book.

How well they have been achieved the reader must judge for himself. To the reviewer, Mr.Dougall's rather forced differentiation between "collective consciousness" and his "group mind," with the provisional rejection of the former and unqualified acceptance of the latter, is quite illustrative of the type of difficulty that is encountered in the book and that is bound to lead to considerable confusion. A reading of *The Group Mind* strengthens the conviction that a satisfactory sequel to the author's *Introduction to Social Psychology* is yet to be written and that in all probability this will have to be done by some one who is in greater sympathy with modern psychological tendencies than is McDougall.

Bernard Glueck.

New York School of Social Work.

The Nervous Housewife. By Abraham Myerson, M.D. Boston: Little, Brown and Company, 1920. 273 p.

Those who are wholly in accord with Freud's doctrine of the neuroses will naturally find themselves out of sympathy with the author's treatment of this subject, but it is doubtful whether on this account even the most confirmed Freudian will fail to recognize the real and abiding merit of this book. The author has put into clear and simple language the ordinary, everyday manifestations of nervousness in the housewife of our day and time, and in his lucid discussion of causation has escaped the widespread fallacy of seeking for something profound and complex. On the contrary, due weight is given here to the commonplace events and conditions of American life which create the setting in which nervousness thrives, and the error is made obvious of neglecting to take into account, in the treatment of these individuals, these determining environmental factors.

Physicians, especially those who are busily preoccupied with mental pathology, will do well to heed carefully the author's reference to the social-pathologic issues involved in psychiatry, since the troubles of our patients reflect so largely disturbances in their external economy.

The author has clearly grasped the significance in human life of the "urge to put oneself across" and sees with great clarity the nervous reactions called forth by a balking of this urge. Thus the nervousness of the housewife becomes an occupation neurosis and its prevention will depend upon our capacity to devise means that will make it possible for the average housewife to achieve, in spite of the oppressive monotony of her daily task, an increasing feeling of worth and dignity as an individual. The book is written very entertainingly and with a charm rarely met with in medical treatises.

BERNARD GLUECK.

New York School of Social Work.

WAR NEUROSES AND SHELL SHOCK. By Frederick W. Mott, M.D. London: Oxford University Press, 1919. 348 p.

Possibly to many readers books about "what the war taught us" have become uninteresting and tiresome; but while this may be true of books in general on the problems of the war, scientific books are in a group by themselves, because they have to do primarily with scientific investigation and progress, rather than with military topics. What Mott has written is of particular interest, not solely because of his standing as a scientific authority, but also because of the unusual opportunities that he had for scientific study.

The book does not, as the title would indicate, deal solely with war neuroses and "shell shock," in the sense in which such terms are generally accepted in this country; it deals also with concussion, carbon-monoxide poisoning as related to the nervous system, the effects of irritant gases upon the brain, and other organic conditions of the nervous system.

The text is not for those who have no knowledge of the functional neuroses or of the organic nervous system. Often cases are described without any interpretation being offered. Mott presents these clinical pictures and case histories without any effort to substantiate an organic or psychogenic theory, but merely with the idea of describing conditions as he saw them. Indeed, one feels that Mott himself has no confirmed theories as to when certain symptoms are to be regarded as of organic origin and when of psychogenic. Some cases, as presented, seem contradictory, or at least seem to have both functional and organic features. This method of presentation, however, does not detract from the value of a book, although it would confuse one who has had no knowledge of, or experience with, the war neuroses.

The first part has to do with histological changes found in con-

cussion cases, causations of different kinds of shock, and the supposed effect of "windage," and these pathological descriptions are illustrated by excellent plates and figures in the text.

The latter part of the book has to do with psychological and pathological functioning, hysterical states, paralysis, contractures, malingering, psychoses, alcoholism, etc. and various forms of treatment are considered.

The interest and value of this book rests on more than scientific considerations. It is dedicated as follows: "To a Group of American Medical Officers Who Worked With Me at the Maudsley Hospital this little book is dedicated as a friendly mark of appreciation of their earnestness and efficiency in the study and treatment of cases of war neuroses admitted under my care."

These officers gained in ways other than scientific by their association with Mott. Besides an intimate personal relationship, which they will never forget, they became interested in English ways of thinking of psycho-pathological matters; such men as Mott, Rivers, and McDougall, to mention but three, present subjects from a point of view somewhat different from our own. Again, the English medical officers must have gained likewise in their association with the dozen or so American medical officers from the neuropsychiatric service of the United States Army. If an interchange of ideas of this kind could happen more frequently, and did not have to depend upon such a catastrophy as war to bring it about, medical science would undoubtedly gain by it.

Sanger Brown, II.

New York City.

The Mediæval Mind; A History of the Development of Thought and Emotion in the Middle Ages. By Henry Osborn Taylor. New York: The Macmillan Company, 1919. Vol. I, 603 pages; Vol. II, 621 pages.

The title of these two volumes, of over 1200 pages in all, may be somewhat misleading to its readers, as it was to the reviewer. The book does not exactly discuss the qualities of the mind of man of the mediæval period, but there are contained in it historical facts, accounts of religious fanatics, and political and social records, which enable one to appreciate to a considerable extent the meaning of some of the peculiar trends of thought of that period—trends similar to those seen today in psychopathic people.

Of a period in the mental development of the race earlier than the mediæval, we have access to some interesting observations. Ethnolo-

gists particularly have collected such data—Rivers on the Todas, Hewitt and Spencer on the primitive Australians, Boas on the aborigines of this country, and such men as Tyler, Frazer, Gilbert Murray, and Andrew Lang, to mention but a few. These writings give us a considerable degree of insight into the mind of so-called primitive man. Of the mediæval period, we have no observations of this particular kind. Taylor's book does not furnish us with them, but he does furnish us with a great deal of interesting data about this semicivilized period—semicivilized, at least, in many respects.

These volumes are too scholarly and too full of details and quotations of various kinds to be dealt with properly in a review. The reader will find presented many interesting facts about the religious, social, political, and military life of these early centuries. As a rule, these descriptions are impersonal, and they have to do with institutions; when they have to do with individuals, as is occasionally the case, they are most illuminating.

Take, for example, Romuald the Hermit's fight against evil. "The devil would come striking on his cell, just as Romuald was falling asleep, and then no sleep for him. Every night for nearly five years the devil lay on his feet and legs, and weighed them down with the likeness of a phantom weight, so that Romuald could scarcely turn on his couch. How often did the devil let loose the raging beasts of the vices! And how often did Romuald put them to flight by his dire threats! Hence if any of the brethern came in the silence, knocking at his door, the soldier of Christ, always ready for battle, taking him for the devil, would threaten and cry out: 'What now, wretch! What is there for thee in the hermitage, outcast of heaven? Back, inclean dog! Vanish, old snake!' He declared that with such words as these he gave battle to malignant spirits; and with the arms of faith would go out and meet the challenge of the foe."

While conduct of this kind, extending over a period of five years and doubtless much longer, is scarcely to be regarded as indicating a psychosis, similar actions at the present time would arouse grave doubts of a man's mental equilibrium. The whole condition has to be considered in its setting and interpreted as a part of the spirit of the times.

Again, take this case of an ascetic woman, this time described by Jacques de Vitry:

"I saw another who sometimes was seized with ecstacy five-and-twenty times a day, in which state she was motionless, and on returning to herself, was so enraptured that she could not keep from displaying her inner joy with movements of the body, like David leaping before the Ark. And I saw still another who, after she had lain

for some time dead, before burial was permitted by the Lord to return to the flesh, that she might on earth do purgatorial penance; and long was she thus afflicted of the Lord, sometimes rolling herself in the fire, and in the winter standing in frozen water."

Conditions of this kind, probably not understood in their psychological significance by the author of the book, are of assistance in interpreting similar states that we see to-day in psychopathic people. For this reason the volumes are of value to the psychiatrist. The text is replete with quotations and references, whose full meaning may not be understood by the ordinary reader—were not, at least, by the reviewer—but there is also much psychopathological material in the text that will be understood only by those familiar with psychological mechanisms.

SANGER BROWN, II.

New York City.

FATIGUE STUDY. By Frank B. Gilbreth and Lillian M. Gilbreth. New York: The Macmillan Company, 1919. 175 p.

The central thesis of this excellent little book is that there is a huge loss to the nation—and the world—in preventable fatigue. "Fatigue study has principally to do with that part of the science of work that is most necessary for producing large outputs." The book deals with the fatigue problem in industrial plants, and the study itself is based on the measurement of movement.

The authors discuss both the sources of fatigue and the remedies. The sources of fatigue, for the Gilbreths, lie in bad worktables, poorly built chairs, wrong types of clothing; poor lighting, heating, and ventilation of the workshop; insufficient rest hours and overlong hours of work, etc. In other words, the physical basis of fatigue is studied, and remedies are suggested in what is obviously efficient—good tables, proper chairs, efficient lighting, rest hours—and the like. Incidentally the authors recognize some form of happiness as the aim of life and urge elimination of fatigue not only because fatigue hampers production, but because it hampers happiness.

This plainly written book is a worth-while investment for everybody interested in industry, social welfare, and mental hygiene. The reviewer wishes, however, that some one would deal with the fatigue that arises from blocked purposes, hopeless outlook, thwarted instinct, deviated character—in other words, with the psychological factors in fatigue. Incidently, industry is becoming more and more based on that greatest of fatigue-producing factors—*monotony of occupation.*

A. MYERSON.

Tufts Medical College.

MANUAL OF PSYCHIATRY. Edited by Aaron J. Rosanoff, M.D. New York: John Wiley and Sons, Inc., 1920. 684 p.

This is a very readable book and one worth any one's permanent ownership. It has some chapters not usually found in textbooks of psychiatry, and notably the too short chapter on the social aspects of psychiatry. Dr. Rosanoff shows his progressive spirit in thus recognizing that psychiatry, like the rest of medicine, must officially add the social worker to its armamentarium. Also, the lessons of the war have been utilized, and thus the volume is modernized in a commendable manner.

There are some glaring defects in the book which the reviewer points out in the friendliest spirit. Chief amongst these is the disproportionate handling of the various topics. Psychiatry should recognize that the psychoneuroses are the most common of the mental diseases and give them more than the twenty-seven pages that this volume allots. Neurasthenia, which is here barely mentioned, is a mental condition, and is perhaps the most common of all diseases.

One may grant an author the privilege of considering psychoanalysis of the Freudian type at some length and neglecting all other forms of psychotherapy, except for four pages of extract from a layman's book. But how reconcile the seventy pages given to free association tests and the fact that pellagra is merely mentioned? By space allotment, the editor of the book evidently considers these tests as important as dementia praecox, manic-depressive psychoses, and the psychoneuroses combined. And while we are willing to see the revisions of Binet-Simon given eleven pages, we cannot reconcile ourselves to the six pages given to the senile psychoses or the ten pages given to feeblemindedness and the associated problems.

The chapters on syphilis are excellent and one can unreservedly commend the excellent analysis made of the phenomena of psychiatry as related to age, marital condition, heredity, etc.

A. MYERSON.

Tufts Medical College.

NURSING IN MENTAL DISEASES. By Harriet Bailey, R.N. New York: The Macmillan Company, 1920. 168 p.

This book marks a definite step forward toward the more general recognition of mental nursing as an art founded on science. It is apparently the first textbook on the care of the mentally sick written by a nurse for nurses. With the increasing attention now being given to mental disease, its prevention, treatment, and cure, it is essential that nurses should have a textbook that gives in lucid style

and logical sequence the underlying science as well as the developed technique of treatment.

In her opening chapter, entitled *Psychological Introduction*, Miss Bailey describes mental mechanisms in simple language and dwells on habit domination and the possiblities of re-formation. This chapter might well be studied at the beginning of every course in general nursing. A brief, but arresting, chapter follows on the history of the treatment of the mentally sick both in Europe and America.

A striknng innovation in such a textbook is the chapter on *Prevention*. This bears witness to the hopeful modern attitude towards the burden of mental disease, and from the beginning properly gives the student a look through the windows of the institution into the great field of opportunity outside. The remarks on qualifications for mental nursing emphasize the modern recognition of the fact that the most successful work with mental patients demands the highest intellectual and spiritual gifts. The day of custodial care by kindly, but ill-educated and untrained, attendants is passing. The time has come when education and skilled nurses will make a contribution to better methods of care and treatment of mental cases, such as has been conspicuous in the field of medicine and surgery.

Chapters on symptoms, nursing measures, accidents and emergencies, occupation therapy, and hydrotherpathy are written from the standpoint of a teacher who knows every detail from a practical experience illuminated by an alert intelligence. Psychotherapy and psychoanalysis are briefly discussed, and the significant statement is made that the physician's efforts may be nullified by a nurse who does not understand the principles of treatment. The possibilities and limitations of treatment of the mentally deficient are outlined, and the revised edition of the Binet-Simon tests for intelligence is included in the section on mental defect.

The book contains so much information desirable for every nurse that it should be welcomed in every school of nursing. Instruction in psychiatry will soon be included in every first-class course of training, and Miss Bailey's book will prove a practical guide to the highest standard of mental nursing.

V. M. Macdonald, R.N.

The National Committee for Mental Hygiene.

The Psychology of Nationality and Internationalism. By W. B. Pillsbury. New York: D. Appleton and Company, 1919. 314 p.

Professor Pillsbury gives us a psychological analysis of national group-experience. He attempts to compromise between McDougall's

emphasis upon the instincts as a basis for social life and Trotter's interpretation of gregarious fear and social control by convention. Nationality is treated as a psychological product built by experience upon the common social instincts and expressed by the ideals of the nation-group. The League of Nations is merely a new type of group-consciousness, and there is nothing belonging to the human instincts that forbids the successful working-out of super-nationalism. Some of the chapter titles of the book are: *The Nation as a Psychological Unit—Social Instincts, Hate as a Social Force, The Nation as Ideal, Nationality and Super-nationality as Expressed in a League of Nations.*

The author glides easily over the difficulties that stand in the way of any international organization such as the League of Nations. For example, he does not appreciate the significance of early childhood experience in localizing and limiting social sympathy. The book carries the atmosphere of a hurried production, and there is textual evidence that it matured quickly.

The book is a demonstration that social psychology cannot make much headway with practical political problems until it can come to a more reasonable agreement with reference to the number of characteristics of human instincts. At present anything needful for political or social theory is drawn by the psychologist from man's equipment of instincts with the ease with which jugglers in our childhood brought forth the "plug hat" rabbits and other marvels.

ERNEST R. GROVES.

Boston University.

TOY-MAKING IN SCHOOL AND HOME. By R. K. & M. I. R. Polkinghorne. New York: Frederick A. Stokes Company, 1920. 299 p.

To one who for many years has been preaching the value of a hobby as a part of mental hygiene, it is refreshing to find the following: "One need scarcely fear for the future of the child, however dull and mechanical her daily work as a grown-up person may be, if she has abundant interests in life—if she can use and love to use in leisure moments hammer, saw, and file, or if she has some other healthy hobby. Still, for those who like the pleasant noise and pleasant mess caused by tools, it is hard to find a happier occupation than toy-making. A toy-maker becomes at once a collector of useful odds and ends, and a collector—that is, one who collects willingly the things he likes—is always a happy person; the toy-maker becomes, too, the contriver, one who can adapt materials to different purposes, and the giver—for the finished article must be disposed of." If this is not

sufficient to prove to the mental hygienist the value of manual work—and especially of toy-making—the reader is referred to the introduction to this book written by the headmistress of the County Secondary School, Streatham, in which she quotes from answers made to a questionnaire by ten- and eleven-year pupils, the first question being: "If you like handwork, say why; if not, say why you do not." "Out of forty-five papers, one answer was against handwork—'Because I do not like sawing.'" To the question, "Has it done you any good?" a fair number thought it made them careful or patient or more useful; others seemed to think that the exercise in sawing had some good effect on the arms; one said that her "fingers are better for music;" another that it has made her "not so flabby and fat." These are but a few of the delightfully naive opinions expressed.

The greater part of the book is given over to descriptions of toys and directions for making them. These are, as a rule, brief because the numerous illustrations—over five hundred—make much detail unnecessary. There is, however, no sacrifice of clearness. As may be imagined, the majority of the toys are simple of construction, in some cases so simple as to appear a bit crude, but these are intended for the younger children, the "infants," and it is emphasized that originality and a perfection of detail are to be encouraged. From these simpler toys there is careful grading to those more difficult of construction. An excellent idea is the construction of several group toys, such as a tournament, a mediæval market, or war engines of the past. These naturally stimulate the child to take a greater interest in his history lesson and secure a firmer association of the facts learned. There are also a number of mechanical toys that will appeal to the child who delights in machinery.

The book will be of value both to the teacher and in the home where there may be a child who likes to make things. The fact that English coins and other unfamiliar objects are used as comparisons will naturally stimulate the child to investigate them and so broaden his conceptions. The materials used are the simplest, and emphasis is laid upon the utilization of waste, which we suspect may be a minor hobby of one or both of the authors. The necessary tools required are very few in number, and ordinary household appliances are pointed out as substitutes.

To the teacher or occupational aid there is much that is stimulating in the book and many of the designs will be found to be likely to interest patients by their novelty. The book is heartily recommended.

W. R. Dunton, Jr.

Sheppard and Enoch Pratt Hospital

NOTES AND COMMENTS

Connecticut

A bill to establish a psychopathic hospital in New Haven at Yale University will be introduced in the 1921 legislature of Connecticut.

Illinois

The last General Assembly appropriated $1,000,000 for the construction of a group of research and educational hospitals in Chicago. Among the first buildings to be constructed will be a psychiatric institute, a new eye and ear infirmary, and an institute for crippled children. A joint agreement has been entered into by the University of Illinois and the Department of Public Welfare, whereby the university is to provide the professional service and the department to assume the administrative functions of the group. An interesting account of the movement to construct these hospitals, an outline of their purposes, and a description of them, with illustrations and floor plans, are found in the December, 1920, number of *The Modern Hospital*. The subject is reviewed from the standpoints of the university, the Department of Public Welfare, and the architects.

Massachusetts

The Psychopathic Department of the Boston State Hospital has been made a separate state hospital by legislative enactment. It is hereafter to be known as the Boston Psychopathic Hospital. Dr. C. Macfie Campbell, formerly of the Henry Phipps Psychiatric Clinic, Baltimore, is the new Medical Director. Dr. Douglas A. Thom will have charge of the out-patient department.

Minnesota

Interest is being expressed in the establishment of a state psychopathic hospital at the University of Minnesota. It has the indorsement of the State Medical Society, many state and municipal officers, and social workers. It is proposed to have a hospital of at least 70 beds to be placed in the university hospital group and conducted by the medical school under a joint arrangement between the university and the State Board of Control.

Tennessee

In September, 1920, a law was enacted to amend Chapter 150, Laws of 1919, establishing a state institution for the feebleminded, which was summarized in the April, 1919, issue of MENTAL HYGIENE.

The new law allows the Board for the Administration of State Institutions to select as a site property not belonging to the state, and carries an appropriation of $100,000 for the payment of the land and any necessary expense in establishing and opening the institution. The former law restricted the board to a site owned by the state and appropriated only $10,000 for the establishment of the institution in addition to an appropriation for maintenance.

Texas

The Northwest Texas Hospital for mental diseases, which was authorized by the 1917 legislature, is nearing completion. The East Texas Hospital, authorized the same year for colored patients, was opened September 1, 1919.

Virginia

A law to provide for the extradition of persons of unsound mind was enacted by the 1920 legislature. This law is similar to those in effect in Illinois, Maryland, Massachusetts, Nevada, Tennessee, and Wisconsin.

Chapter 262, Laws of 1920, has amended and reënacted certain sections of Chapter 46 of the Code of Virginia. These sections relate to insane, feebleminded, epileptic, and inebriate persons, including regulations pertaining to the institutions for their care, commitment procedure, and conveyance of patients.

Another act of the same legislature makes it a misdemeanor to marry knowingly any person lawfully adjudged to be insane, epileptic, or feebleminded. Any marriage shall be void without any decree of divorce or other legal process.

Chapter 339, Laws of 1920, relates to persons charged with crime whose sanity is doubted, persons becoming insane after conviction, and the disposition of those who are confined in the department for criminal insane charged with a crime. One of its outstanding provisions is for the commitment to a hospital for mental diseases or a colony for the feebleminded for proper care and observation of any person charged with crime, pending the determination of his mental condition, who appears to need such commitment. If the person is on trial, the trial may be suspended. The superintendent of the hospital or colony must inform the court of the condition of such person as often as the court may require.

Federal and State Coöperation in Building Hospitals for Ex-Service Men

Last August the Hon. R. G. Cholmeley-Jones, Director of the Bureau of War Risk Insurance, sent an urgent appeal to the Governor of the State of New York to join with the Federal Government in providing a special hospital for the treatment of ex-service men and women suffering from nervous and mental diseases. The project, as outlined by the Director of the Bureau of War Risk Insurance and accepted immediately by the state, involves the construction by the state of a hospital for one thousand such patients, and its lease to the United States Government for a period of ten years at an annual rental amounting to one-tenth of the cost of construction. Although the legislature was in extraordinary session to consider housing legislation, the governor sent a special message, and on September 26 the bill was passed by both the Senate and the Assembly, becoming a law on September 27.

The Military Hospital Commission created by the act immediately began the preparation of plans, and on October 13 these plans were approved by the State Hospital Development Commission. After many weeks of negotiations, the Secretary of the Treasury decided that he did not have the power to sign the required agreement, and on December 10 he transmitted a letter to Congress requesting that he be granted such power by legislative action. A joint resolution was introduced in the Senate and the House of Representatives authorizing the Secretary of the Treasury to enter into an agreement to lease hospitals acquired or to be constructed by the state of New York or other states for the care and treatment of beneficiaries of the Bureau of War Risk Insurance. This resolution has been reported favorably by the House Committee on Public Buildings and Grounds, but unfavorably acted upon by the Senate Committee on Appropriations. Friends of the ex-service men in New York who are dissatisfied with the care such patients are receiving are unanimous in their demand that the hospital be constructed either through agreement with the government of the United States or, if the joint resolution fails, by the state of New York. Considerable interest is taken in other states in this project. Action by Congress on the resolution and action by the state upon the proposal that it proceed to build the hospital itself are awaited with much interest. This project is thought to be sufficiently important to justify printing here both the New York State act and the joint resolution:

LAWS OF NEW YORK.—By Authority.

Chap. 958

AN ACT to provide for the construction, by the state, of a hospital for discharged soldiers, sailors and marines, from the state of New York, suffering from mental diseases, and making an appropriation therefor.

Became a law September 29, 1920, with the approval of the Governor. Passed, three-fifths being present.

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. A hospital is hereby established, to be constructed as herein provided, for the care and treatment of discharged soldiers, sailors and marines, suffering from mental diseases, who volunteered or were inducted into military service from the state of New York and who are or may hereafter become beneficiaries of the bureau of war risk insurance. Such hospital shall be known and designated as the New York Military Hospital.

§ 2. A commission is hereby created, for the purposes of this act, to consist of the state architect, the state comptroller, the attorney-general, a representative of labor and a member of the medical profession, to be appointed by the governor. Such commission shall serve without compensation and shall be known as the commission for military hospital.

§ 3. The commission for military hospital shall enter into negotiations and may make an agreement with proper authorities of the United States, whereby the state shall agree to construct such hospital and the parties shall agree that the state shall lease the same, when ready for occupancy, to the United States for a term not exceeding ten years at an annual rental, to be paid by the lessee, of not less than one-tenth of the total cost of such hospital; but the parties may estimate and determine the maximum cost on which such percentage shall be computed. The United States shall agree to equip, use and maintain such hospital, at its expense, exclusively for the care and treatment of discharged soldiers, sailors and marines mentioned and described in section one of this act. Provisions, satisfactory to the officers executing the agreement, and not inconsistent with this act, also may be included in relation to the care and treatment of the inmates of the hospital, and otherwise to carry out the objects and purposes of the hospital.

§ 4. Such hospital shall be located upon lands in the borough of Queens, city of New York, heretofore authorized by chapter four hundred and seventy-three, laws of nineteen hundred and eight, as a site for the Long Island State Hospital. Upon the organization of the commission for military hospital the jurisdiction granted by chapter four hundred and seventy-three, laws of nineteen hundred and eight, to the state hospital commission over the lands hereby selected as the site for the New York Military Hospital shall terminate.

§ 5. Such hospital shall have a capacity of one thousand beds and shall be constructed by the commission for military hospital. By this act an emergency is recognized, and the commission for military hospital, in the construction of such hospital, is hereby relieved from compliance with the provisions of the state finance law and the public buildings law relating to advertising, receipt of bids, the letting or making of a contract or contracts and the separate approval of contracts by the comptroller, and is hereby authorized to construct such work in any way deemed most advantageous for the completion of the hospital at the earliest possible date, and to enter into the open market and purchase materials or

supplies, employ labor and make payments of bonuses in consideration of extra effort and efficiency or for overtime work. Such commission, and any contractor therewith, is also hereby relieved, in the prosecution of such work, from complying with requirements of the labor law in so far as they prohibit any person engaged upon such work from working more than eight hours during any calendar day. Contracts may be let and moneys expended, in the construction of such hospital and the purchase of land for a spur track, to an amount not exceeding three million dollars.

§ 6. Such work shall be done pursuant to drawings, designs, plans and specifications to be prepared by the state architect, and approved by the hospital development commission.

§ 7. When such hospital is ready for occupancy, the commission for military hospital shall execute, in behalf of the state, the formal lease to be made pursuant to the agreement provided for in section three of this act, which lease shall embody the covenants and conditions of such agreement. Upon the termination of such lease, such hospital shall be deemed a state hospital within the meaning of the insanity law.

§ 8. The sum of three million dollars ($3,000,000), or so much thereof as may be necessary, is hereby appropriated for the purpose of carrying out the provisions of this act, but no part of such appropriation shall be available for the acquisition of land for a spur track or for the construction of such hospital, until the agreement provided for in section three shall have been executed. The commission for military hospital is hereby relieved from compliance with the provisions of the civil service law and rules and may employ at any time such experts and other assistants as it may deem necessary for the proper development of plans, soil surveys, test pits, test borings and conduct of such work, and the moneys appropriated shall be immediately available for their compensation and expenses, and for the expenses of the commission for military hospital, either within or without the state. The moneys appropriated shall be paid out by the state treasurer on the warrant of the comptroller upon certificate of such commission or a majority of its members. Upon the requisition of such commission, the comptroller, from time to time, may advance to the commission such moneys as he shall deem necessary, from moneys appropriated by this act and available for the objects and purposes of the advancement.

§ 9. This act shall take effect immediately.

STATE OF NEW YORK,
Office of the Secretary of State. } *ss:*

I have compared the preceding with the original law on file in this office, and do hereby certify that the same is a correct transcript therefrom and of the whole of said original law.

FRANCIS M. HUGO
Secretary of State

The following joint resolution (No. 223) was introduced in the Senate of the United States on December 14, 1920, by Senator James W. Wadsworth, Jr., of New York:

Authorizing the Secretary of the Treasury to enter into an agreement to lease, or to execute lease for hospitals acquired or to be constructed by the State of New York or other States of the United States of America for the care and treatment of beneficiaries of the Bureau of War Risk Insurance.

Whereas the State of New York has passed an act (chapter 958 of the Laws of 1920, State of New York) authorizing the construction of a hospital for the care and treatment of one thousand beneficiaries of the Bureau of War Risk Insurance suffering from mental and nervous disorders, and having appropriated therefor the sum of $3,000,000 for the construction of such hospital, and has provided a site in the city of New York, Borough of Queens, upon which said hospital shall be constructed, and

Whereas there is urgent need for additional hospital facilities for the care and treatment of veterans of the World War who have suffered injury or contracted disease by reason of their active military service: Therefore be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That the Secretary of the Treasury is hereby authorized to enter into an agreement with the commission for military hospital of the State of New York, pursuant to the provisions of chapter 958 of the Laws of 1920, State of New York, to lease and thereafter to lease, in accordance with the provisions of said Act, subject to appropriations by the Congress of the United States, the hospital to be known as The New York Military Hospital to be constructed by said commission, when said hospital shall have been completed and ready for occupancy.

Sec. 2. That, subject to appropriations by the Congress, the Secretary of the Treasury is hereby authorized to enter into an agreement to lease with the duly authorized representatives of any State of the United States where governmental hospital facilties are urgently needed or to execute a lease for a period not exceeding ten years, and on such terms and conditions as he may deem proper, hospitals which have been acquired or constructed or may be acquired or constructed by such State for the purpose of providing additional hospital facilities for patients of the Bureau of War Risk Insurance.

Citizens of Colorado Vote for Psychopathic Hospital

With a majority close to 100,000, the citizens of Colorado at the November election voted favorably on a bill authorizing an appropriation for a state psychopathic hospital. The vote is particularly significant as this was not a fortunate year for initiated measures, as is shown by the fact that six of the ten initiated measures failed.

The Colorado Legislature in 1919, although it passed a bill authorizing the building of a psychopathic hospital to be located in Denver and to be under the auspices of the Regents of the University of Colorado, failed to pass an appropriation for construction. That the project might not fail at this point, the Colorado State Medical Society undertook to secure a sufficient number of signatures (some 18,000) to a petition initiating a bill appropriating $350,000 for the construction of the hospital. The task was an unprecedented one in medical legislation but the signatures were secured. Immediately preceding the election, an active general campaign of education was conducted. Audiences listened to discussions of the League of Nations, and of psychopathic hospitals and the care and treatment of patients with nervous and mental disease, from the same platform.

This is the first measure of its kind ever voted upon by an electorate in this country, and the Denver Psychopathic Hospital will be the first psychopathic hospital west of the Missouri River.

Mental Defiency Surveys

During the year 1920, the National Committee for Mental Hygiene, through its Mental Deficiency Division, has conducted surveys in West Virginia, Maryland, Missouri, and Wisconsin. These investigations have been made at the request of the governors of these states, and in one state, Wisconsin, as a result of a joint resolution passed by the houses of the legislature. All of these surveys have been under the general supervision of Dr. V. V. Anderson, an Associate Medical Director of the National Committee.

The general aim behind the requests for such surveys has been the desire upon the part of public authorities and interested persons throughout the state to know how far the state was failing to meet the urgent needs of the mental defective; what was the extent of the problem; what its menace; its relationship to other problems, such as crime, pauperism, and the like; and, finally, in the light of information gathered, what ought to be done in order adequately to handle the situation.

In these surveys the National Committee has employed a staff of psychiatrists, psychologists, and psychiatric social workers; and the studies made have included not only investigations of the facilities now provided by these various states for recognizing, training, supervising, and segregating mental defectives, but a very careful investigation into the relationship that mental deficiency bears particularly to delinquency, dependency, and to education. In this way the inmates of state prisons, reformatories, industrial training schools, houses of correction, workhouses, jails, houses of detention, and delinquents passing through the courts have been studied in order to show what bearings mental deficiency has upon crime; inmates of state dependent schools, orphanages, almshouses, dependent families in connection with social agencies in cities and towns have been examined in order to determine the relationship that mental defect bears to dependency; and, finally, large groups of school children in typical public schools have been studied to find out what proportion of the public-school children are feebleminded and in need of special-class instruction or prolonged institutional care and training. In one state, Wisconsin, 7,000 school children in typical schools throughout the state have been studied; in West Virginia about 5,000 school children.

Constructive programs have been mapped out in each state to

enable public authorities to meet the urgent needs of this large and potentially dangerous class.

In Wisconsin the following plan is to be presented for legislative consideration:

1. Compulsory mental examination of all children three or more years backward in their grades, utilizing for this purpose the psychological department already existing in the office of the superintendent of public schools and the occasional use of the flying clinic from the Psychiatric Institute.

2. Compulsory special-class instruction of all children in the public schools diagnosed mentally defective, these special classes to be developed more along the lines of handwork, manual instruction, and trade training than the ordinary academic and regular grade work of the public-school classes.

3. State-wide supervision of all feebleminded children needing such care; this after-care to be carried on under the direction of the State Board of Control.

4. Adequate institutional care for all feebleminded persons who cannot be satisfactorily handled under supervision in the community.

5. Parole, under carefully selected parole officers, of all suitably trained institutional cases fit for community life.

6. Mental examination of all inmates of the state industrial schools, dependent schools, state reformatory, and state prison; such examination to be conducted by a flying clinic from the Psychiatric Institute.

7. Mental examination of defective delinquents and other abnormal mental types in court. Permissive legislation enabling any court in the state to call upon the Psychiatric Institute for the services of a psychiatrist in attendance at the court.

8. Legislation enabling any judge to commit for a period of observation, ten or twenty days or more, to the Psychiatric Institute, any individual whose mental condition is in question.

9. The organization of special care for adult defective delinquents, using machinery already existing at the Central State Hospital as a basis for such work with males; using the new institution at Tachita for female defective delinquents.

In Missouri five important points have been stressed in the National Committee's recommendations:

1. More adequate institutional care for defectives: this to be accomplished by enlarging the Missouri Colony for the Feebleminded at Marshall, with the provision at this institution for additional facilities along the lines of manual, industrial, and trade training, and farm-colony treatment.

2. A new commitment law.

3. Organization of a traveling mental clinic to meet the needs of the public schools.

4. State-wide supervision of mental defectives in need of such care.

5. Reorganization of the present state machinery for handling insane, defectives, and epileptics, so that some constituted central authority shall have supervision and control of the state hospitals, the state institutions for the feebleminded, mental clinics in the public schools and in the community, and after-care work with the insane and defectives.

Missouri already has a compulsory special-class law.

In West Virginia there exists no separate state institution for the feebleminded. In this state some six hundred odd feebleminded persons are now being cared for in the three state hospitals along with the insane. It was deemed best in this state to concentrate upon two important points: the enactment of a proper commitment law, and the creation of a separate state institution for the feebleminded, equipped with the most modern facilities for the care, training, and treatment of mental defectives.

The Maryland survey will continue over into 1921, and a complete program has not as yet been mapped out for this state, although the need for larger institutional provision, special-class instruction, proper mental diagnosis of defective children in the public schools, and after-care work or supervision have already stood out as being very urgent questions in this state.

In each state, advisory committees have been appointed by the governor to assist the National Committee in conducting its surveys. The advisory committee in Wisconsin is composed of Dr. Cornelius Harper, Secretary of the State Board of Health, Chairman; Dr. W. F. Lorenz, Director of the Psychiatric Institute, Secretary; and Dr. Jos. Evans, Professor of Medicine, University of Wisconsin.

The field staff employed by the National Committee in Wisconsin consists of Dr. Smiley Blanton, Dr. Christine Leonard, Dr. Elizabeth Woods, and Miss Mina Sessions.

In Missouri the advisory committee appointed by the governor is composed of the following: Dr. G. Jones, Secretary, State Board of Health, President; J. L. Wagner, Secretary, State Board of Charities and Corrections, Secretary; Hon. Sam A. Baker, State Superintendent of Public Schools; Dr. Malcolm Bliss, President, Missouri Society for Mental Hygiene; Rhodes E. Cave, Chairman, Missouri Children's Code Commission; Charles A. Ellwood, Professor of Sociology, University of Missouri; Dr. E. J. Goodwin, Secretary and Editor, Missouri State Medical Association; L. A. Halbert, Secretary-Treasurer, Missouri Conference for Social Welfare; George Melcher,

Director, Bureau of Research and Efficiency, Kansas City Schools; W. R. Painter, Chairman, Missouri State Prison Board; J. E. W. Wallin, Director, Psycho-Educational Clinic, St. Louis Public Schools; Dr. R. P. C. Wilson, Superintendent, Missouri Colony for Feebleminded and Epileptic; A. F. Kuhlman, Assistant Professor of Sociology, University of Missouri; J. Kelly Pool, Member Missouri State Prison Board; and Dr. E. J. Goodwin.

The National Committee's survey staff in this state are Dr. Thomas H. Haines and Mr. C. L. Hultgren.

In West Virginia the advisory committee appointed by the governor is composed of Dr. L. V. Guthrie, Superintendent, Huntington State Hospital, Chairman; Mrs. Woodson T. Wills, Vice-chairman; James S. Lakin and J. Walter Barnes, State Board of Control; L. H. Putnam, Executive Secretary, State Board of Children's Guardians; Dr. V. T. Churchman, State Board of Health; L. L. Friend, State Department of Schools; and J. S. Pauley, Secretary-Treasurer, State Federation of Labor.

The field staff is as follows: Dr. Frank J. O'Brien, Dr. Arabella Feldkamp, Dr. Esther S. B. Woodward, and Miss Elizabeth Greene. In this state Dr. Guthrie, Superintendent of the Huntington State Hospital, and Miss Davis, of the Board of Children's Guardians, were detailed by the governor to assist, and during the last few weeks of the survey, Miss Sarah Porter and Miss Mary Marshall were furnished by the state to assist in this work.

In Maryland the advisory committee appointed by the governor is composed of the following persons: Dr. Lewellys F. Barker, former President of the National Committee for Mental Hygiene; Dr. George Barnett, Professor of Statistics, Johns Hopkins University; Mr. Robert Biggs, President, St. Vincent de Paul Society; Dr. Edward N. Brush, President, Mental Hygiene Society of Maryland; Dr. William Burdick, Public Athletic League; Mr. Albert S. Cook, Superintendent, State Department of Education; Dr. Francis Lee Dunham, Psychiatrist, Maryland Child Labor Commission; Dr. Knight Dunlap, Professor of Experimental Psychology, Johns Hopkins University; Dr. J. N. T. Finney, State Board of Education; Mr. Charles Fox, Board of Labor and Statistics; Dr. Frank J. Goodnow, President, Johns Hopkins University; Dr. Arthur P. Herring, Secretary, State Lunacy Commission; Mr. Howard C. Hill, Executive Secretary, Prisoners' Aid Society; Miss Theo Jacobs, Associate in Social Economics, Johns Hopkins University; Mr. George Jones, Executive Secretary, Henry Watson Children's Aid Society; Dr. Frank J. Keating, Superintendent, Rosewood State Training School; Mr. Louis H. Levin, Executive Secretary, Federated Jewish Charities;

Mr. O. Margury, Chairman, State Board of Control; Dr. Adolf Meyer, Director, Henry Phipps Psychiatric Clinic; Mr. Jacob M. Moses, Board of Directors, Mental Hygiene Society of Maryland; Dr. John R. Oliver, Psychiatrist, Supreme Bench of Baltimore City; Mrs. Edward Shoemaker, President, Women's Civic League; Dr. Charles B. Thompson, Executive Secretary, Mental Hygiene Society of Maryland; Dr. William H. Welch, President, State Board of Health; Dr. Henry S. West, Superintendent, State Department of Education; Major William B. Wright, Director, Baltimore Alliance; Dr. Hugh H. Young, President, State Lunacy Commission.

The survey in Maryland is being conducted by Dr. William B. Cornell. Both Dr. Edith Michael and Miss Elizabeth Greene have at some time or other been employed in this work. During 1921 Dr. Cornell will be assisted by Dr. Christine Leonard and Miss Mina Sessions.

Comparable methods and similar technique have been employed in each state. The data obtained are therefore uniform in character and will lend themselves readily to comparative and cumulative treatment.

National Health Council

A conference of a number of the leading national voluntary health agencies was held in Washington on December 10, 1920, at which meeting a National Health Council was created, a form of organization approved, and a constitution and by-laws adopted. The membership of the council is at present composed of nine organizations, the officers recently elected being as follows: Chairman, Dr. Livingston Farrand; Vice-Chairman, Dr. Lee K. Frankel; Recording Secretary, Dr. C. St. Clair Drake. The election of a treasurer was deferred until further consideration could be given to the whole question of financing the project.

The council was the outgrowth of many efforts in past years to coördinate national voluntary organizations, initiated by the American Public Health Association, the American Medical Association, and other agencies. These measures culminated in a special health coördination study carried out during the summer of 1920, under the direction of Dr. Charles J. Hatfield, Dr. Watson Rankin, and Dr. Livingston Farrand, with the financial aid of the American Red Cross. This investigation was conducted by Dr. D. B. Armstrong.

At a preliminary conference in Washington, at the call of Dr. Farrand, on October 18, 1920, the need for such a coördinating body was fully discussed, and a temporary organization perfected, Dr. Farrand acting as Temporary Chairman, and Dr. Armstrong as Temporary Secretary.

The organization conference on December 10th, referred to above, approved of the following list of activities, as indicating the legitimate field in which the council might function:

1. A special information bureau
2. A legislative bureau
3. The coördination of health activities
4. Periodic joint conferences
5. A statistical bureau
6. The development of educational health material.

It is anticipated that financial resources, from the Red Cross and from other participants, will be sufficient to enable the council to establish an office and staff and to undertake first those activities promising the greatest benefit to member organizations.

In accordance with the by-laws adopted by the council, each member organization has appointed one representative and one alternate. The original members are as follows: American Public Health Association, American Red Cross, American Social Hygiene Association, Council of State and Provincial Health Authorities, Council on Health and Public Instruction of the American Medical Association, National Child Health Council, National Committee for Mental Hygiene, National Organization for Public Health Nursing, National Tuberculosis Association.

The by-laws provided that "other national health organizations may hereafter be elected to membership by 2/3 votes of the members." Provision is also made for advisory or conferring, as well as directly participating, members. The International Health Board probably will, together with official agencies such as the United States Public Health Service, be associated with the council in this capacity.

Many important matters before the council, given partial consideration at the last conference—such as office, staff, budget, resources, etc.—were referred to a subcommittee made up as follows: Dr. William F. Snow, Chairman; Dr. C. St. Clair Drake, Dr. Charles J. Hatfield, Dr. Lee K. Frankel, with the council chairman, Dr. Livingston Farrand. It is expected that this committee will report its deliberations to the council at a meeting early in January, following which the organization should be in a position to proceed with the development of its program.

The Public Health Council, representing as it does many prominent national health agencies, should serve as a valuable clearing-house and coördinating center in many fields where common functions are performed. It aims to be an integrating force among independent, autonomous agencies, rather than a merger of such agencies into one

organization. It should increase the economy and effectiveness of operation, should eliminate duplication of effort, and should enhance opportunities for sympathetic and constructive public service. Such a movement, through its membership, and through a mutually helpful relationship with state and local voluntary health agencies, should effectively serve the declared object of the National Health Council, which is "the betterment of health work in the United States."

Mental Hygiene in France

Dr. Paul-Maurice Legrain, Chief of Medicine in the French Cabinet, has recently been in the United States studying the mental-hygiene movement. In the department of medicine in the French Cabinet there is a division devoted to the study of mental hygiene. During the war, Dr. Legrain was Psychiatrist of the District of Paris and, as a part of his work, handled all military questions with medico-legal aspects.

Missouri Society for Mental Hygiene

A meeting was held in the office of Dr. M. A. Bliss, 301 Humboldt Building, St. Louis, Missouri, on the 26th of last November for the purpose of organizing a Missouri Society for Mental Hygiene. Those who attended the meeting were Dr. George Johns, Superintendent of the City Sanitarium, Dr. James McFadden, Dr. Frank R. Fry, Mr. Emil Tolkacz, former Director of Public Welfare of the City of St. Louis, Dr. M. A. Bliss, and Dr. Thomas H. Haines, Director of the Missouri Mental Deficiency Survey. Judge Charles W. Holtcamp, of the Probate Court, and Judge Hugo Grimm, of the Circuit Court, who had expected to be present, but were detained, later expressed their hearty coöperation in the plans adopted at the meeting, and agreed to act as members of the organizing group.

Dr. Bliss was elected president and Dr. McFadden secretary of the new society. At the suggestion of Mr. Tolkacz, it was decided that each member of the group should make out a list of persons whom he considered likely candidates to help in organizing the first board of directors; that Dr. McFadden and Dr. Bliss should compare these lists and eliminate duplications; and that each member of the group should then receive a revised list with a form letter, which he would send out as a personal letter to the people on his list. It was felt that the personal touch would be of value in such an organization program.

Later reports state that responses to these letters have been most encouraging, as a large number of acceptances have been received from persons prominent in the various professions and representing a wide range of civic interests.

Mental Hygiene; American Public Health Association

One of the largest attended section meetings at the meeting of the American Public Health Association, held in San Francisco in September, was the session of the Sociological Section on mental hygiene. The following papers were read: *Psychiatry and Public Health,* by Eva C. Reid, M.D.; *Mental Health of Children,* by Glenn E. Myers, M.D.; *Social Aspects of Mental Defect,* by Harold W. Wright, M.D.; and *Public Health Education and Mental Hygiene,* by Frankwood E. Williams, M.D. Among those who took part in the discussion were Dr. Olga L. Bridgman, San Francisco; Dr. F. W. Hatch, Sacramento; Dr. Andrew W. Hoisholt, Napa; Dr. C. W. Mack, Livermore; Dr. Lillian J. Martin, San Francisco; Dr. V. H. Podstata, Livermore; Dr. Robert Lewis Richards, Talmage; and Mr. August Vollmer, Berkeley.

Correction

The editors regret an error that was overlooked in the copy of the article *State Institutions for the Feebleminded,* published in the July, 1920, number of Mental Hygiene. The statement "so that now only five states in the Union have failed to make any institutional provision for their feebleminded, West Virginia, New Mexico, Arizona, Nevada, and Idaho," should be changed to read, "so that now only five states in the Union have failed to make separate institutional provision for their feebleminded, West Virginia, New Mexico, Arizona, Nevada, and Utah."

The Aims of Mental Hygiene

"To stem the tide of syphilis, to wage war on alcohol, to counsel against marriage of defectives, to generalize the insane hospitals, to specialize the general hospitals, to weed defects out of general school classes, to open out the shut-in personality, to ventilate sex questions, to perturb and at the same time reassure the interested public—these are infinitives that belong perhaps in a rational movement for mental hygiene. They are things the past has taught us more or less clearly to do and in that sense the movement for mental hygiene is surely not much more than the elaboration of the obvious."—*E. E. Southard.*

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